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ABSTRACT

Prepared by the National Institute of Mental Health staff and grantees, this report gives not only the quantitative research data, but also demonstrations of community mental health efforts that serve as excellent models for other communities to follow. Chapter I presents An Introduction: The Setting and an Overview; Chapter II, Studies of Rural Life and Mental Health: epidemiological and demographic studies, the attitudes of rural delinquents and rural suicide rates. Chapter III, New Approaches to Rural Mental Health Service, covers closing the gap between hospital and community, and mobilizing and strengthening community resources, while Chapter IV, Community Mental Health Centers in Rural America, details these centers, staffing, financing, transportation, and regional differences. Chapter V, Rural Mental Health Centers: Five Case Histories, centers on Appalachia, the Northeast Kingdom (Vermont), Aroostook County (Maine), Down East (Maine), and Prarie View (Kansas). Chapter VI, State Hospitals with Rural Patients, presents the Hospital Improvement Program and grants for Hospital Staff Development; Chapter VII, Supplying the Manpower, discusses continuing education and experimental and special training programs. Chapter VIII presents the summary and "a quick look ahead". (KM)

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THE MENTAL HEALTH OF RURAL AMERICA

The Rural Programs of The National Institute of Mental Health

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FOREWORD

In 1969, the National Institute of Mental Health published a report on *The Mental Health of Urban America*, describing the major programs of the Institute focusing on urban populations. That report served its purposes well. They were to provide an overview of the Institute's aims and efforts in dealing with the mental health problems of our cities; to make clear the Institute's role in the broad collaborative effort necessary to improve the quality of our urban life; and to demonstrate through examples how agencies and communities can move to meet problems of urban mental health. This companion report shares the same aims with respect to the NIMH's rural programs.

The beauty of the countryside and the satisfactions of rural life have been sung with good reason, as one can see even today when many farmers have been forced off the land, when dirt lanes have become asphalt roads, and when the livelihood of many rural families depends upon the encroaching factory. Almost anywhere in America a person who goes into a rural county with mind open and senses alert will perceive a different and deeper kind of beauty than that to be experienced in the city.

But the longer a visitor remains, the more he is likely to be impressed not only by the loveliness of the surroundings but also by the misery of many of those living among them. He may find that rural regions are afflicted with numerous problems usually associated in the public mind with life in the inner cities. He may come to know, firsthand, families crowded into shanties, old trailers, or other inadequate quarters, without plumbing and perhaps without even a water supply; families who have to make long trips to the welfare office; homeless, in-and-out-of-jail alcoholics as well as alcoholics with good homes they seem bent on trying to destroy; anguished parents of children who are retarded, or disturbed, or delinquent; and the troubled faces or unreasonable behavior of other persons in need of psychiatric help.

For the truth is that the troubles of our urban population get a preponderance of attention from journalists and sociologists—rightly so in view of the number of people involved—but the troubles of our rural population are generally similar and in some cases proportionately worse. For example, poverty, often a factor in both physical and mental illness, is significantly more extensive in rural than in urban America. An even greater disparity between city and country lies in the ability of these areas to handle problems of mental health; while the shortage of mental health personnel and facilities is nationwide, it is particularly severe in our rural areas.

In a great many rural communities, nevertheless, the interested visitor will also find a growing awareness of mental health problems, a widening realization that they are both treatable and, often, preventable, and an increasing determination to develop the needed services. By describing the pioneering efforts in a number of these communities—made with NIMH encouragement and support, in collaboration with local or State groups and often with other Federal agencies—this report not only demonstrates what is being done but also suggests what can and should be done to meet the mental health problems of rural America.

Bertram S Brown

BERTRAM S. BROWN, M.D.
Director
National Institute of Mental Health

PREFACE

This report draws upon the work of a sizeable number of NIMH staff members and grantees working in behalf of the Institute's research, training, and service programs. The report demonstrates how the varied activities of the Institute are brought to bear on a single pressing problem involving a broad segment of American society. Reported here are not only quantitative research data but also demonstrations of community mental health efforts that serve as excellent models for other communities to follow.

Because the report was developed over a period of many months, some of the work presented here as in process may in fact have been completed, and newer projects in the area of rural mental health started. But the original purpose of the report continues to be served: to demonstrate the kind and the range of rural mental health activities in which the Institute is involved.

This report was prepared by NIMH's Program Analysis and Reports Branch, collaborating with those segments of the Institute whose specific programs are described. In the preparation of this volume, Dorothea L. Dolan, Special Assistant for Rural Mental Health, Division of Mental Health Services Programs, provided invaluable guidance.

JULIUS SEGAL, Ph.D.
Chief, Program Analysis
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One day in the country
Is worth a month in town.
—*Christina Georgina Rossetti*

At Rome, you long for the country;
when you are in the country, fickle,
you extol the absent city to the skies.
—*Horace*

CHAPTER I

INTRODUCTION: THE SETTING AND AN OVERVIEW

This report considers the problems of bringing mental health services to rural areas and describes how the National Institute of Mental Health has moved to solve these problems through its support of:

1. Research and demonstration projects on rural needs and on ways of meeting them;
2. Community mental health centers that are making mental health services available to rural dwellers;
3. Programs to improve State mental hospitals serving large numbers of rural patients;
4. Programs to train professional and paraprofessional mental health workers for service in rural areas and provide training in mental health principles and practices for people who are already working there in some role related to mental health.

Rural America and Its Citizens

By Bureau of the Census definition, rural Americans are those who live in the open country or in communities of less than 2,500 people. Urban Americans are those who live in urbanized areas or in communities of 2,500 or more outside of urbanized areas.

The rural population today is only a little larger than it was

50 years ago—about 54 million in 1970 as compared to about 52 million in 1920. During these same 50 years, the total population, 203 million in 1970, has almost doubled, and the urban population has almost tripled. (*1*)

While the rural population has remained at almost the same level during the last half century, the farm population has become an increasingly smaller part of it and the nonfarm element increasingly larger. In 1920, three-fifths or 32 million of the rural population were farm people; in 1970, only one-fifth, or 10 million. Thanks to mechanization and other advances in agriculture, fewer and fewer people are producing more and more food. During a recent 4-year period, an average of 600,000 persons a year—or more than 6 percent annually—left the farm population.

Despite losses in farmers, farm workers, and their families, most rural counties in the Northeast, the East North-Central States, and the Far West grew in population during both the 1950's and the 1960's. Counties that lost are concentrated in the Great Plains, the Corn Belt, Appalachia, and sections of the Southern Coastal Plains. Over all, the outmigration of farm people has been offset to some extent by an inmigration of city people—to work in industries established in rural areas, to commute, or to live in retirement. A study based on the 1967 Survey of Economic Opportunity found that 24 percent of the white rural population and 11 percent of the black were people who had moved there from urban areas.

Rural Americans constitute little more than 25 percent of the population, but they live in 2,100 predominantly rural counties that occupy about 90 percent of the land.

Rural people, like urban, differ greatly in their life-styles. Around large cities and their suburbs, there may be 200 or more rural dwellers per square mile, and most of the adults may commute to urban areas. At the other extreme, large areas in the mountains of the Western States are practically uninhabited, with an average of perhaps one person in 10 square miles. In many Southern and Midwestern areas, "rural" is still almost synonymous with "agricultural." But in the southern Appalachians rural economy is often based on mining and welfare; and in parts of the Carolinas, on many scattered textile and clothing mills. (*2*)

Incomes differ widely, too. For example, a 1967 survey of families living in the open country of a relatively affluent area—Ohio, Indiana, Illinois, Michigan, and Wisconsin—found that 11 percent were economically deprived. (*3*) Open-country poverty in this area was only slightly higher than among whites in general. Another 12 percent of the households, however, were on the margin of poverty.

In contrast, of the households surveyed in the Mississippi Delta—including parts of Missouri, Arkansas, Mississippi, and Louisiana—and in the Southeast Coastal Plain of South Carolina, fully one-half were judged to be suffering from economic deprivation. And another large group, about 16 percent, had only marginal incomes. In the Ozarks, comprising parts of Missouri, Arkansas, and Oklahoma, about one-fourth of the households were economically deprived, and more than another one-fourth were on the edge of poverty. (4)

At the end of 1970 this country had 25.5 million people, or 13 percent of the total population, who were under the poverty level. Figures for 1969 show that the proportion of such persons was almost twice as high in rural and other nonmetropolitan areas as in metropolitan areas. In 1970 the percentage of persons in nonfarm families below the poverty level stood at 9.6; of persons in farm families, at 18.6. Families dependent on farm wageworkers were particularly poor. The average annual wages of these workers in 1970, for both farm work and nonfarm work, totalled $1,640. Farm wages averaged $11.10 a day; nonfarm, $16.35.

The unemployment rate for all experienced workers in industry, including agriculture, was 4.8 percent in 1970; in agriculture it was 7.5 percent. Underemployment, too, in rural areas is chronic and severe. The farm wage earners mentioned above worked on the average only 127 days in 12 months. New jobs are not being created fast enough to meet the growing need—and many rural people do not have the education or the training to compete for the new jobs that do become available when industry moves in.

About 3 million rural adults in 1960 were classified as functional illiterates, having had less than 5 years of school. More than 700,000 had never enrolled in school. Nearly 20 million had not completed high school—a number that increases every year as rural youth drop out of school before graduating. In 1970, approximately one-fourth of the country's total population over 25 years old had gone to school 8 years at the most. Among nonfarming people outside the metropolitan areas, this was true of 32 percent; among farming people, of 43 percent.

As with income and educational levels, housing in rural areas is often poor—even by urban slum standards. Nonmetropolitan areas have 30 percent of the population but 60 percent of the nation's substandard housing units.

Problems of Health and Health Care

As might be expected from the relatively low average levels of income and education, the rural regions of this country have a relatively high level of health impairments. Indeed, the proportion of persons with activity-limiting chronic health conditions—which include mental illness as well as heart conditions, arthritis, high blood pressure, visual impairments, and some orthopedic impairments—has been found to increase with rurality. When allowances are made for the greater proportion of the elderly in rural areas, the percentages of people with such conditions in 1963–65 rose from 9.8 in large metropolitan areas to 11.9 in other metropolitan areas, to 14.1 in other nonfarm areas, and to 15.4 in farm areas. (*5*)

To what extent this situation is linked to the availability of health services cannot be said. But rural communities in general do have fewer health, mental health, and other social service facilities than cities, and rural people have to spend more time and money getting to them. Also, the income from taxes in these communities is low because there is little industrial tax base and because incomes are generally low. Yet rural populations include larger percentages of children, old people, and poor people, all of whom have health needs higher than average.

Further, the country's general shortage of professional health manpower is most severe in rural areas, where the professional faces heavy patient loads, isolation from colleagues, and, often, inferior health and educational services for himself and his family. In 1969 there were 500,000 people living in 134 counties without physicians—36 more such counties than in 1963. On the average, however, rural counties have about as many general practitioners, in proportion to population, as more populous counties, though the doctors tend to be older and far more burdened, and may not be replaced as they retire. The great disproportion is in medical specialists. In 1966 there were eight specialists per 100,000 persons in isolated rural counties and 45 in isolated semirural counties—those having at least one township of 2,500 or more people. The number shot up to 95 in the smaller metropolitan counties and to 137 in the larger.

In the matter of hospital beds, as in the matter of GP's, a rural area may stack up fairly well in sheer numbers as against an urban area. But rural hospitals are more often inadequately staffed and poorly equipped and therefore less often accredited.

The health resource imbalance has been particularly severe in professional mental health workers and in mental health facilities. Of more than 16,000 psychiatrists who reported their place of work in an NIMH survey in 1965, only 500—or 3 percent—were in rural counties. The individual states have the responsibility for the care of their mentally ill and mentally retarded, and the standards of care differ widely. In the four most rural States, the acceptable ratio of psychiatric beds per 1,000 population is only one-tenth of that in the four most urban States.

Too often, mental hospitals in rural sections—as in urban also—have offered only custodial care to patients considered hopeless. In one State, for example, "hopeless" cases have long been cared for in several dozen county mental hospitals. An Institute-supported survey of the attitudes and opinions of the superintendents of these hospitals—many of whom had grown up in the hospitals and eventually taken over their fathers' jobs—found that 76 percent of the sample regarded patients simply as children in need of constant supervision. (*6*)

The lack of adequate mental health facilities often leads to inappropriate treatment of persons in need of psychiatric services. Alcoholics, juvenile delinquents, abandoned children, and people who are confused or psychotic are frequently housed in local jails—sometimes for just a day or two, sometimes longer. The more affluent rural residents often can, and do, turn to professionals and facilities in distant cities for mental health services, but money and transportation both are serious problems for the rural poor.

In short, the country offers advantages—in fresh air, space to move around in, and daily contact with nature—that many of its dwellers would not trade for an apartment or townhouse, no matter what the city. But it also has certain disadvantages, particularly in the quality and distribution of its health care and other social services, which fall with special severity on its poor people. And there are relatively more poor people in rural areas than in urban, and rural slums can be even more dispiriting than urban slums.

Overview of the Report

In the same fashion as the companion work on urban mental health, this report shows how the intermeshing NIMH programs in mental health research, mental health manpower training, and mental health services work toward the solution of rural mental health problems. It should be emphasized that much of the Institute's work deals with mental health problems common to Americans, and indeed to mankind, whether they live in the country or the city and is, therefore, not reported in this volume. Such work includes research on the origins, prevention, and treatment of mental illness and on means of preventing or offsetting those factors in early life that may predispose a child to emotional problems; and those, too, that may predispose him to a low level of intellectual functioning.

The major chapters of this report contain examples of Institute activities which, though overlapping, deal with different aspects of rural mental health problems.

- Chapter II describes some of the research efforts to get the information needed to plan, and most effectively deliver, mental health services to rural populations. Among the work reported are studies of the prevalence of mental illness in different sections, the attitudes of rural people toward mental illness and the mentally ill, the effects of urbanization, and the extent of suicide and the characteristics of the suicidal person. Also included is a group of studies of the American Indian who, of all our rural people, probably stands most in need of help to improve the quality of life.

- Next, Chapter III takes up a number of new approaches to mental health services in rural areas—some of them efforts to have the State mental hospital and the community work more effectively together in the interest of both; others, efforts to make fuller use of resources already available, in addition to the State hospital, to alleviate the mental health service crisis.

- Chapter IV deals with the Community Mental Health Center program for rural America. It discusses the problems common to most of these centers—problems of meeting expenses, acquiring an adequate staff, and extending services throughout their catchment areas, which are often geographically very large; tells briefly how some centers meet these problems; and reports evidence of the program's success.

- To provide a closeup picture of rural community mental health centers in action, Chapter V presents five case histories, which include details of how the centers are serving their communities, how they are meeting problems of money and manpower, and how some centers have responded to the need for special programs in such fields as alcoholism, delinquency, and the mental health of children.

- Chapter VI describes through many examples how the Institute's Hospital Improvement and Hospital Staff Development programs have raised the capabilities of State mental hospitals serving large rural populations and helped them to discharge to the community a large proportion of even long-term patients.

- Chapter VII discusses how NIMH is helping to meet the need for mental health manpower—on which depend both the delivery of mental health services and the pursuit and application of new knowledge—by supporting a rich variety of training programs. These programs are directed at increasing not only the number of mental health professionals but also the ability of the rural physician, teacher, clergyman, and other community care-givers to handle the mental health problems they meet in the course of their daily activities. Increasing emphasis is being placed on the development of community mental health workers to more effectively help rural-dwelling blacks, Mexican-Americans, and Indians.

- Chapter VIII summarizes the findings and looks to the future.

This report is not exhaustive in its survey of the Institute's rural program, and the projects included do not necessarily encompass all of the most significant work in a given area. The intention has been mainly to provide a sampling of the varied efforts directed toward the improvement and expansion of mental health services and the manpower concerned with them.

The reference section following Chapter VIII identifies the directors of NIMH-supported projects, the titles of their studies and programs, and the institutions at which the work reported here was done.

Order and simplification are the first steps toward the mastery of a subject—the actual enemy is the unknown.

—*Thomas Mann*

CHAPTER II

STUDIES OF RURAL LIFE AND MENTAL HEALTH

The National Institute of Mental Health supports a number of research projects designed to obtain the information necessary for delivering the kinds of mental health services most needed in rural areas to the people who most need them. These projects include: 1) studies of the prevalence of psychiatric disorders in various regions and among different classes; 2) studies of the information people have about mental illness and of the attitudes they hold toward the mentally ill and toward mental health programs; 3) studies of the effects of social change—such as industrialization of an agricultural area—on the well-being of the individual and the community; and 4) studies of the extent of such mental health problems as delinquency and suicide and of the kinds of persons most susceptible to them.

Among the research projects also are studies of American Indians, a largely rural people who, for good reason, are more than usually vulnerable to certain problems of mental health.

This chapter describes some of the research in rural mental health recently supported or still being supported by the Institute. Each study is intended to delineate a problem, or determine its extent, or uncover its causes, or test a way of dealing with it, or in some other way obtain information useful in planning and delivering services.[1]

Epidemiological and Demographic Studies

In planning a mental health program, the logical first step is to assess the problem that makes the program necessary. What is the prevalence of mental disorder in the population to be served? What groups of people—by age, income, race, and so on—particularly need to be helped? How do people view mental illness and what do they think can be done about it?

Studies of the distribution of mental disorder in urban areas have demonstrated a relationship between the quality of community life and the mental health of the people. They have found that both the type and the incidence of psychological impairment seem to be influenced by socioeconomic factors. Similar studies supported by the Institute have been undertaken in rural areas to help identify the kinds of services that will most effectively meet the needs of these areas.

This section reports on some epidemiological and demographic investigations. The section following it takes up the closely related subject of attitudes.

Mental Health in Three North Carolina Counties

The Community Psychiatry Section of the Department of Psychiatry at the University of North Carolina has been studying the feasibility of mental health programing for rural areas. (*1*) The plan has been to assist two rural North Carolina counties to establish services tailored to their needs and resources and to record the processes and the outcomes for the benefit of other rural areas. A neighboring county in Virginia serves as a control.

The investigators have used questionnaires to study a random sample of 1,405 residents of these three counties. They represent a highly rural and stable population of whites and nonwhites. Eighty percent of them have spent most of their lives on a farm or in a small town. Two-thirds of them have less than a high school education, and only 5 percent have completed college. Most are either unskilled or semiskilled. Forty percent have incomes below the poverty level; the families of 70 percent each have a total yearly income of less than $6,000.

To assess the prevalence of mental or emotional disorder, the investigators used a 20-item measure known as the Health Opinion Survey. The survey dealt mainly with psychoneurotic and psychophysiological symptoms. Possible scores with this instrument ranged from 20 to 60, with a high score indicating a high degree of disorder.

For the three-county sample, the average score was 26.8, which was interpreted as reflecting a relatively healthy population. Seventy-six percent of the sample scored below 30, indicating a lack of significant stress or emotional disorder. An additional 14 percent scored in the range of 30 to 34, usually interpreted as "borderline," or "probable psychiatric disorder." The remaining

10 percent had scores of 35 or over, indicating "psychiatric disorder."

There were no significant differences among counties or between men or women. However:

- Nonwhites as a group had a significantly higher score than whites.
- People who were widowed or divorced and people who were single all had higher average scores than married people.
- Rural people had a slightly higher score than urban—meaning, in this study, people who lived in small towns.

Also assessed were the mental health levels of approximately 400 community leaders and the same number of school teachers. Contrary to the findings of some earlier studies, the teachers came out very well. They had the lowest rate of psychiatric impairment—less than 3 percent, as compared to 5 percent for the leaders and 10 percent for the general public. The teachers did, however, have the highest rate of mild to moderate symptoms—about 1 out of 3, as compared to about 1 out of 4 in the other groups.

The investigators found themselves challenged by these findings "to mobilize appropriate services for at least the 10 percent of the population with scores of 35 and over . . . and for the 14 percent of the population whose scores indicate borderline or probable psychiatric disorder. Beyond this, the study points to the vulnerability and need of certain specific subgroups: rural over small town dwellers; nonwhites over whites; elderly over the young; the widowed, divorced, and single over the married; and the less educated, unskilled worker with less income."

An earlier study of mental health clinics in North Carolina showed that their services were being used mainly by white, middle-class, middle-aged mothers and their children rather than by the groups that, according to the present study, should be the key targets. Attempts being made by the directors of this study to reach these target groups are described in Chapter III.

Surveys in Florida and Illinois

In another project, a 5-year epidemiological survey begun in 1968, the investigator is studying a Florida county that is being affected by urbanization. (*8*) This county has one city. Sixty percent of the people outside of this city live in the open country, along roads and in piney woods areas. Little communities of from 20 to 40 families are not uncommon. The county is typical of many others in the Southeast: racially mixed, industrial as well as agricultural, and ranging socioeconomically from deprivation to affluence.

Data on a wide variety of social, family, and individual characteristics are being collected and their relation to psychological impairment is being studied. Psychological impairment is taken to include psychosomatic illness, emotional disturbance, inability to function in various spheres of life such as work and recreation, and lack of satisfaction with life and one's performance.

In a preliminary study, 41 percent of the persons in the sample were found to be impaired, most of them mildly—32.6 percent of the total. More women in the sample, 47 percent, were impaired than men, 32 percent. Almost 50 percent of the people under the age of 35 were found to be impaired, in contrast to 33 percent of those aged 35–54. The rate of impairment was highest, 57.2 percent, in the 55–64 group. Among persons 65 and over, impairment was 32 percent. Ratings for impairment varied inversely with several manifestations of social status. Impairment was relatively high in persons with relatively little education, and it was 55 percent among the blacks in this pretest sample, 33 percent among the whites.

Another investigation, in rural Illinois, found that 16.6 percent of the people studied had at least a moderate psychiatric impairment. (*9*) This study—like the one in Florida but unlike the one in North Carolina—also found that women had a higher rate of impairment than men. Significantly, all three studies found that psychiatric impairment is most common among people of low socioeconomic status. In this they agree with earlier studies in metropolitan areas and with a study in Montana, reported below. The Illinois project reports also that the prevalence of psychiatric impairment is lower in the rural community studied than in previously studied urban areas, particularly New York City. This remains true when differences in age, socioeconomic level, and patient status are taken into account.

Besides investigating the frequency of impairment in a typical southeastern county, the Florida study is trying to answer such important questions as: What are the specific needs of psychologically impaired people? Which persons use existing treatment facilities, and why? Which persons do not receive care, and why?

State Hospital Patients in a Great Plains State

A vivid illustration of the lack of services in many rural areas, together with an indication of the kinds of mental health service needed, is provided by an investigator who studied State hospital patients discharged to their homes in eastern Montana. (*10*) The research covered 18 counties, an area about the size of Pennsylvania or Louisiana but having a population at the time of the study of roughly 100,000, or only about two persons per square mile.

Close to 200 patients were studied—all those discharged from the State hospital to the 18-county area during a period of 2½ years in 1963–65, except those over 65, those with brain damage, and Indians.

Among the facts that emerged:

- Only 26 percent of those studied had been seen even once by a physician before they were sent to the State hospital.
- Before going to the hospital, almost 40 percent of the patients had been held in jail. About half of these had been in jail longer than 24 hours. Patients were rarely there because of violence. Sometimes they were being held on criminal charges, such as being drunk and disorderly or writing bad checks. Often they were in jail because the community or the county had no other place to house them. In many cases the period in jail proved to be a serious barrier to post-hospital rehabilitation.
- Sixty percent of the patients were taken to the hospital by the sheriff—often because he was the only available transporting agent but sometimes because the community feared the patient and seemed to think the sheriff's involvement served to punish the sick person for his behavior and might be a deterrent both to the patient and others.
- Compared to the general population, the patients were more likely to be older, single, and poorly educated. They were also more likely to have shown patterns of family discord and to have been unemployed or working at a low-level job.

Had there been early diagnostic and treatment services available, the study found that some of the patients would have been spared hospitalization and many would have been spared a long period of illness.

The need for aftercare as well as other mental health services was demonstrated by the rate of return to the hospital. Of the patients for whom detailed case data were obtained during a 3-year followup, almost 45 percent were rehospitalized during that period at least once. This was the case even though the State hospital was so far away—for some sections of the area, about 600 miles—that perhaps many sick people were never sent there. The need for community services was also demonstrated by the poor adjustment of many returned patients. Some could not get work. Others were the victims of families who were inclined to be either punitive or overprotective. A number tried to solve problems by leaving the community.

Thanks in part to this Institute-sponsored research, a rural mental health center has been established to serve people throughout the eastern half of Montana.

The Road to the Hospital

The social process involved in identifying a person as mentally ill is also under study. Specifically, one project in Indiana is examining the part played by certain individuals, such as physicians, clergymen, and family members, in the decision to hospitalize the person seen as ill. (*11*) One goal is to learn what incidents typically lead to hospitalization and what do not. Another is to learn how the manner in which hospitalization takes place is related to the course of treatment and to discharge. The study involves patients of two Indiana State hospitals, one serving primarily an urban area, the other, mainly rural areas.

Social Stress and Mental Illness

Findings taken to indicate that the disintegration of a community—as shown, for example, by broken homes, hostility, inadequate leadership, and unclear goals—produces mental illness are reported by another project. (*12*) In one part of this study, the mental health of people in Stirling County, Nova Scotia, a rural and small town region similar to many in the United States, was compared to that of the Yoruba people in Nigeria.

About one-third of the Stirling County people were found to have impaired mental health. The prevalence and patterning of psychiatric disorders there and among the Yoruba were more similar than different. However, more Stirling County women and more Yoruba men were affected. The investigator thinks this difference may be accounted for by different patterns of stress. In Stirling County, women seemed more exposed than men to stresses associated with social changes. In the Yoruba villages, on the other hand, the women lived according to stable traditions and apart from the men. It was the men who were exposed to the turmoil and uncertainties generated by changes in Yoruba society, and it was the men who were the more likely to have mental health impairments.

Since the disintegration found in the Yoruba villages was recent and had been precipitated by forces outside, the investigator believes that his hypothesis is confirmed: the disorganization of social systems is by itself likely to generate psychiatric disorders. The suggestion is that improvement in community cohesiveness will have among its payoffs a significant reduction in the incidence of mental illness.

The Attitudes of Rural People

The delivery of appropriate mental health services to any community requires information not only about that community's needs but also about its readiness to accept services to meet those needs. For this reason the attitudes of rural populations—as well as urban—toward mental illness and mental health services are being explored with NIMH support in several sections of the country.

People of Two Counties Ask for Services

As discussed earlier, a project in North Carolina has been working to establish a mental health program suited to the needs of two rural counties. (7) One of these counties had a few mental health facilities: a part-time clinic offering minimal services, a struggling mental retardation program, and an active Alcoholics Anonymous group. The other county had none. Few people—only 6 percent of a random sample of the residents—knew that mental health services existed in their area, but these few highly approved of them, and all but 2 percent of the sample felt that additional services were needed. Persons with specific ideas mentioned a mental health clinic most frequently. Only a handful of the residents surveyed—less than 1 percent—had heard about comprehensive community mental health centers.

About 90 percent of the sample thought it would be good to have a psychiatrist in the community. They claimed they would go to such a doctor themselves or send a friend if the need arose. The respondents also felt that other physicians, and ministers and teachers, have an important function in improving mental health. More than 96 percent agreed that these nonpsychiatric professionals can contribute greatly when they are assisted by mental health experts. Over 90 percent agreed that "the family doctor can help prevent mental illness by helping the parents to understand the behavior problems of their children." Not quite 50 percent agreed that a person should be able to get help for his emotional problems from his clergyman. Three out of five expected teachers to handle mild problems in the classroom but only one of two felt that an understanding teacher could be as effective with a disturbed child as a special class would be. A large majority believed that parents are capable of improving the mental health of their children by participating in discussion groups on child-rearing problems.

There was dramatic evidence that mental hospitals are no longer viewed as snakepits. Most people said they would be willing to work in them and felt that the patients received good care, got better, and were released.

The views of the general public about mental illness, its cause, and treatment were compared to those of two groups of persons having an important role in the formation of attitudes—school teachers and community leaders of all kinds. The investigators found that:

- A majority of each group—the public, the teachers, the leaders—share the view that mental illness is the most serious health problem in the country.
- All three groups recognize that mental illness takes many forms, with varying degrees of severity.
- Eight out of 10 respondents consider alcoholism a mental illness.
- In each group, better than 80 percent believe that much can be done to prevent mental illness and that even when mental illness strikes, successful treatment is possible.
- Seventy percent of the general public but only 35 percent of the leaders believe that mental hospitals are needed to protect the community from the mentally ill. About 45 percent of the public but only 12 percent of the leaders think that the hospitals should be surrounded by a high fence and guards.
- More than half of the public and the leaders agree that "it is usually better for the mentally ill person to receive treatment in the community than in a mental hospital."

On the whole, these attitudes were judged to be highly encouraging. Less encouraging were the responses elicited by an attitude scale which presented generally outmoded notions about the causes of mental illness. For example, 40 percent of the teachers and the leaders and 78 percent of the general public agreed that "some people are just born mentally unstable and are almost certain to end up in a mental hospital." Again, only 17 percent of the leaders and 20 percent of the teachers but 51 percent of the public agreed that "one of the main causes of mental illness is the patient's lack of moral strength and character."

An Accepting Attitude—And Also Prejudice

Another part of the same study throws light on an old question: the consequences of labeling a person as mentally ill. Earlier research on this subject produced contradictory findings. Most of the evidence supported the view that when people recognize that a person is mentally ill, they tend to reject him. But there was some evidence to the contrary.

In the present study, people were given four case histories and asked if the facts indicated mental illness. The cases were those of a simple schizophrenic, an alcoholic, an anxiety-neurotic, and an acting-out child, who had been lying, stealing, and playing truant. In each case, more than half of the people with a definite opinion responded that the persons were mentally ill. The proportion was highest—roughly 75 percent among the general public, the leaders, and the teachers—in the case of the schizophrenic and the alcoholic. It was lowest—little more than 50 percent among the general public, somewhat higher in the other groups—in the case of the acting-out child.

Then the people were asked to what extent they would be willing to interact with a person who was termed mentally ill. The instrument used was a six-item "social distance" scale. The items ranged from "I would not hesitate to work with someone who had been mentally ill," at the bottom of the scale, to "I can imagine myself falling in love with a person who had been mentally ill," at the top. The average score on this scale, where a score of 6 indicated acceptance on even an intimate level, was close to 4. And there was very little difference between the people who had identified the cases as mental illness and those who had not. In other words, the investigators found no evidence to support the view that labeling a person as mentally ill will result in a greater degree of rejection and isolation. Instead, the findings suggested that the average rural person in this study had a positive attitude—an accepting attitude—toward people who had been described as mentally ill.

Oddly, the willingness of the general public to interact with former mental patients was found to be significantly greater than that of teachers. This was especially surprising because social acceptance of the mentally ill has often been found to be related to education, and the teachers were in the highest educational bracket. Looking for an explanation, the investigators noted that teachers in any community are in a highly exposed position, may be very sensitive to the consequences of being labelled mentally ill, and as a result feel that close acceptance of former mental patients may lead to "guilt by association."

In studying the attitudes of the people in these counties, the investigators also used a scale intended to show the degree of stigma the residents attached to mental illnesses. The responses were so weighted that scores could range from 20 to 60, and the lower the score, the better the attitude.

The average score for the total sample was 37.6. People in the countryside were found to attach more stigma to mental illness than people in the rural towns. Others with relatively high stigma scores were nonwhites, older people, particularly those over 50, and people ranking low in education, occupation, or income.

It is not wise to generalize on the basis of any one study. But this can be said: The people in these rural counties had had only very limited experience with mental health services, yet their attitude toward such services was highly favorable. This has not been true in every rural area. Further, these people had more realistic views about mental illness than those expressed by other groups in earlier studies. The investigators point out, too, that their findings demonstrate the need for further efforts to educate the public, particularly those demographic groups scoring high on the stigma scale.

As noted earlier, Chapter III, under "Testing a New Pattern of Service," describes a project designed to pave the way for comprehensive mental health services in the two North Carolina counties, and perhaps elsewhere, through the establishment of programs influenced by the survey findings summarized in this chapter.

Guides for Mental Health Programs

A similar study in Wyoming arrived at some findings that were generally similar and others that were different. (*13*) Only 32 percent of the rural residents surveyed knew that their county had a mental health center. Almost 80 percent relied on ministers, physicians, and lawyers for help with their problems. Mental health problems noted most frequently were those of immediate concern to the community and centered on delinquency (30 percent) and the need for more recreational facilities (23 percent). Conceptions of mental health were limited—for example, persons with good mental health were seen as "jolly: nothing seems to bother them much," whereas persons with poor mental health were seen as displaying "bad behavior" and dwelling in the past.

Following this survey the investigators went to a neighboring rural county and examined the attitudes both of community leaders, who presumably mold opinion, and of residents selected at random; the two groups did not appear to differ markedly in their views.

In both of the counties studied, the major causes of mental health problems were seen as societal. Among the subjects frequently mentioned were today's unsettled world, economic pressures and stresses within the county, and failure of the more traditional institutions, such as the church, to provide services. Mental health activities were thought to be concerned mainly with problems related to the family. A person's inability to cope with the stresses of life was considered, nevertheless, to be of minor importance. The community leaders in general believed that a mental health center was needed and gave many suggestions for financing it.

The studies in these two Wyoming counties, the investigators point out, highlight the importance of consultation with resource groups and individuals representing a variety of specialties in the community. Problems in rural mental health should not be the concern of just one or a few allied groups of mental health professionals but of the larger community. This is because some people facing emotional problems will seek out, not a mental health center, but their doctor or minister. Also, certain forms of treatment can be carried into the school more readily by the teacher than by a mental health professional. The community mental health center, through consultation and education programs, can mobilize such community resources.

So far as direct services are concerned, the rural residents of these Wyoming counties appear to have a clear picture of the kinds of problems with which a mental health center is equipped to deal. But they seem to have little understanding of mental health center functions beyond direct service. To some extent this is probably a reflection of the needs of the community: the most obvious one is for direct service. For the most effective promotion of mental health in rural areas, though, the mental health center has an obligation to the total community at least as great as its obligations to the troubled individual.

Differences Between Generations

Studies of aging have been concerned principally with urban populations. To provide more information about the needs of older people in rural areas, an investigator has interviewed 800 persons in eastern Kentucky. (*14*) This is part of the Southern Appalachian Region, which is one of the country's major rural poverty areas. It is also an area in which the total population has been going down but the population of persons over 65 has been going up. Information coming from the study is to be used in improving services directed toward the elderly, here and elsewhere.

The persons interviewed were selected to provide a range of socioeconomic status and to permit comparison both between generations and between rural and urban residents. So far the analysis has shown differences in attitudes and values between generations regardless of dwelling place. Older people both in rural and urban sections were significantly more worried by financial, family, and world problems. There has been an indication, too, that old age occurs earlier—at least in people's minds and attitudes—in rural than in urban areas. In the country, both the older and the younger generations gave the period between 22 and 45 as the life stage of most respect and influence. Urban people, though, selected the period between 45 and 64.

Rural vs. Urban Day Hospital Patients

Evidence that former mental patients tend to function in their homes and communities at about the same level as their families expect has been reported by a number of investigators. The level of expectation in the facilities to which many patients are released, such as halfway houses and boarding homes, has also been found to influence the behavior of the patients. Among the factors bearing upon the family's expectations, one study has found, are the type of illness, the prognosis when the patient was discharged, and the family's socioeconomic status—the higher the status, the higher the expectations. These studies dealt with urban patients who had been in mental hospitals.

Now a research team supported by NIMH is comparing the attitudes and expectations of families and patients in an urban setting with those of families and patients in a rural setting. (*15*) Pretreatment data have been collected on patients admitted to two day-hospitals, one serving residents of Baltimore who might otherwise need full-time hospitalization, the other serving residents of a Maryland agricultural county "in transition from distinctly rural to spottily suburban." The study sample included 40 urban and 49 rural admissions and a close relative of each. The two patient groups were roughly similar in clinical histories and, except for the rural-urban difference, in demographic characteristics.

Preliminary findings are in agreement with those of earlier studies: performance of socially expected activities tended to vary with the level of expectation held by the relatives. When expectations were high in relation to those of the rest of the group, performance also tended to be relatively high. A patient's own expectation, too, was related to his performance. There was a slight but consistent tendency for level of expectation to increase with social status.

A number of significant differences between the rural and urban groups were found in behavioral measures:

- Rural patients were rated by their relatives as less helpless and more stable than their urban counterparts. These same patients were judged by clinicians to be more adaptable, less impaired, and less perceptually disturbed than the urban patients but more grandiose and hostile.
- Less than half of the rural patients were felt to be a source of distress to the family, compared to almost three-fourths of the urban patients.
- Performance of socially expected activities, as reported by relatives, was higher for the rural than the city patients, though the two groups did not differ greatly in the average levels of relatives' expectations. Consequently, dissatisfaction with patient performance was greater in the urban than in the rural group of relatives.

The investigator points out that in general the urban patients seemed to be more disturbed than rural patients as measured by such predominantly passive-type symptoms as helplessness, instability, and impairment. Rural patients, on the other hand, seemed more disturbed than city patients in their manifestations of such active and interpersonally offensive symptoms as hostility and grandiosity. As a possible explanation, the investigator suggests that the urban patient who is excited, hostile, and grandiose is more likely than the rural patient with the same symptoms to land in a full-time hospital. To a greater extent than city residents, perhaps, country people are allowed to be individuals, even "characters." Acceptance of conspicuously abnormal behavior seems greater in rural than in urban areas.

Looking at the other side of the picture, the investigator suggests that symptoms such as helplessness and lack of adaptability imply cultural demands on the patient and that the demands made on individuals in the country are less stringent than those made in the city. Perhaps the rural patient was rated lower in such symptoms because life had presented fewer tests of his adequacy.

Comparative treatment outcomes will be reported after further study of the two groups.

Progress and a Continuing Need

In the North Carolina project described earlier, the investigators compared the attitudes of the rural people in their sample with those of people, primarily urban, in studies going back as far as 1950. (7) The overall impression is of a significant change for the better during recent years in public understanding of the nature of mental illness. The more recent data suggest that both rural and urban people, particularly the better educated, "are becoming more sensitive to behaviors indicative of mental illness and more willing to seek out psychiatric and medical resources to cope with the problem."

As one possible reason for this change in the public's perceptions of mental illness, the study cites "the intensive mental health movement of the past 10 to 15 years" and goes on to say: "It is somewhat difficult to point to a specific item, place, or organization that is responsible for this new perspective on mental illness. It can be said, however, that the National Association for Mental Health, through its State and local affiliates, has played a leading role in the dissemination of information concerning mental illness. The role of the Federal Government has been extremely important. Under the sponsorship of the U.S. Department of Health, Education, and Welfare, much research and training have been undertaken. The results of these studies have come to the attention of the public largely through the mass media. . . . During this period also, significant changes have come about in State mental health programs, and very many more local community programs have come into existence. Closer relationships between these official programs and the citizens have developed as joint efforts for program planning and legislative appropriations have been effected. Official mental health agencies most often have organized information and education programs, and community groups have more and more accepted them and used the services provided. The resultant breakdown of the isolationism of the traditional mental health systems and the cultivation of free communication between them and the public have undoubtedly contributed to the positive changes in information and attitudes found in this study."

Despite the advances, the investigators conclude, much is still to be done. Information from projects that survey attitudes and understanding about mental health issues is important because the development and acceptance of a mental health program rest upon it. "There is a continuing responsibility," the investigators point out, "to help enlighten people who know little about mental illness and are not certain where to turn when they encounter the need for help."

Studies of Urbanization

The process known as urbanization includes the movement of people and industry, and of the services on which they depend, into formerly rural communities based on agriculture and also the movement of people from rural societies into urban settings. Both types of movement may bring stress to those making the move and to those among whom they settle. Investigators supported by the Institute have been studying the mental health implications of the rapid social change engendered by either type.

Sudden Industrialization of a Rural Area

One research team is studying what happens to the people and the social arrangements in a rural area when it is suddenly industrialized. (*9*) The area is Putnam County, a region in North Central Illinois that was entirely rural and predominantly agricultural when a steel company quietly bought up land and in 1966 began constructing a huge plant, which went into operation two and a half years later.

The investigators began collecting sociological information about the region in 1966 and continued intermittently until mid-1971. After the data have been analyzed, they expect to report how industrialization has affected both the people of the area and such organizations as county government, business firms, schools, churches, and the labor market. They expect also to assess the impact of rapid social change upon the community's mental health status and needs.

Several interesting preliminary findings have emerged:

- The proportion of county high school students who did not know what occupation to choose after graduation almost tripled—going from about 10 percent in 1966 to about 32 percent 4 years later. It might be supposed that the increase could be charged to the new vistas opened by the coming of the mill. However, high school students in a control county, not industrialized, showed very much the same pattern. The investigators are tempted to link the rising uncertainty in both cases to the general youth movement. This interpretation would be consistent with sociologists' expectations about the consequences of rapid changes in the social order and the value structure of society, but it is speculation.
- Contrary to previous findings in urban areas, no connection appeared between maternal employment on the one hand and maladjustment among adolescents on the other. Again, this was true both in the industrialized area and in the control county. Juveniles whose mothers were employed were more likely to be favorably disposed toward employment for women generally.
- No substantial relationship appeared between work motivation and students' age, sex, and class in school or their parents' education, occupation, and income.

As noted earlier in this chapter, the study also has found that symptoms of mental illness are more prevalent among persons of low socioeconomic status and less prevalent in this rural area than in several urban areas studied previously.

Rural-to-Urban Migrants

A dozen years ago, another research team studied 800 families, about evenly divided among blacks, Anglos, and Mexican-Americans, who had migrated to Racine, Wisconsin. It turned out that the groups differed markedly in the extent to which they had been absorbed into the economy and integrated into the culture, and that race and ethnicity were the principal factors accounting for the differences. For example, backgrounds of education and work that gave Anglos a certain place on the socioeconomic scale were not sufficient to place blacks at the same level. Again, the higher one's education, the higher one's occupational status—but only in the case of the Anglos. More blacks than Mexican-Americans had increased their socioeconomic status. In the case of the blacks, the single factor most highly related to absorption was previous urban industrial experience. Close identification of Mexican-Americans with their ethnic community retarded advancement.

Now, the investigators are restudying the 800 families to determine what combinations of individual characteristics and group identities determine the level at which the migrant is initially absorbed and the rate at which he moves upward. (*16*) A second restudy deals with the migrants' perception of reasons for progress or lack of it toward their goals. (*17*) The studies will help answer why demographic variables that correlate with occupational status in the majority group do not do so in the case of some minorities.

Other projects on the effects of rural-to-urban migration include a study—using as subjects Mexican-American migrants from California and New Mexico to Denver—of the individual characteristics and the social processes that lead to the success or the failure of rural migrants (*18*) and studies of Indians who have settled in Denver (*19*) and the San Francisco area. (*20*)

Studies of American Indians

American Indians are the most deprived of all the Nation's minority groups of opportunity for a good education, for employment at a decent income, and for a rewarding life. The resultant problems of mental health are reflected in very high alcoholism, suicide, and student dropout rates. Some of the Institute-supported projects to uncover information useful in combating the cycle of frustration, alienation, and failure that afflicts these predominantly rural people are reported in this section. The studies in the field of education in particular have applicability to other minority groups.

Educational Problems

Although the quality of education offered to rural youth today is superior to what it was a generation ago, educational achievement among rural students—particularly members of minority groups—is still lower than among urban youth. Rural students drop out of school sooner than urban students, and the percentage of rural high school graduates who attend college is much lower than for urban youth. The American Indian is unusually handicapped. Educational attainment among Indians is the lowest in the Nation—5 school years, on the average, for all Indians under Federal supervision. The dropout rate for Indians is twice the national average in both public and Federal schools. The achievement level of Indian children is from two to three years below that of white students, and the Indian child falls farther behind the longer he stays in school. Few Indian students succeed in reaching college level, and the attrition rate among Indian college students greatly exceeds that for non-Indian students.

Among Institute-supported projects to test or to recommend ways of offsetting the factors that make for educational failure among disadvantaged minority students, particularly Indians, an especially promising venture is Project Catch Up. (*15*) This is a 6-week summer enrichment program in Bellingham, Washington, for 50 disadvantaged junior high school students. Most of these students are American Indians; the others, Mexican-Americans and Anglos. The program is concerned with junior high school students because disadvantaged youth typically begin to experience feelings of alienation, rejection, and depression at about the eighth-grade level, and the highest dropout rates are found among secondary school students. The director points out that the usual Upward Bound program is aimed at the intellectually able child about to finish high school; for most children like those in Project Catch Up, particularly Indians and Mexican-Americans, it is too late because they have already dropped out.

The Bellingham project, which could be replicated in other locales, rural or urban, is an educational program to increase academic achievement, alter negative self-images, and assist in planning for the future. It is given at Western Washington State College, where the students and teachers, who are public school personnel, live for 6 weeks. The students attend regular classes and participate in culturally enriching and recreational activities.

The research goal is to determine whether or not an intensive summer program can effect changes in intellectual functioning, academic achievement, social maturity, and motivation to achieve in disadvantaged youngsters of 13 and 14. This is an important question. A number of authorities hold that the environmental manipulation necessary to offset the effects of cultural deprivation must occur when the child is very young; hence the current emphasis throughout the country on early childhood educational programs.

Followup studies by Project Catch-Up show a significant lowering of the dropout rate, as compared to that of students not in the project, generally more positive views of self-worth than those held earlier and, with two exceptions—scores in arithmetic and, for the girls, on a mental maturity test, both of which remained the same—significant improvement in the results of all other psychological measures and achievement tests. This was in the face of previous evidence that the academic achievement of disadvantaged adolescents either remains stationary or declines. The lower dropout rate is credited in part to the fact that a field representative, gathering followup data, is in periodic contact with all the students who have participated in the summer program.

The Anglos have shown the greatest improvement; the Indians, the least. "It would appear," the project reports, "that those adolescents who experience comparatively the most advantaged circumstances are the most available for change."

One of the most important achievements is the teachers' increased awareness—brought on by living with the students day in and day out—of the emotional problems confronting disadvantaged youngsters. The project has collaborated with a mental health clinic to help students and teachers deal with these problems and has used consultation with public school administrators to produce greater support for the project students and their fellows.

The value of making special efforts to help minority group members continue their education is further shown by the experience of Brigham Young University, where NIMH supported a study of the college adjustment of Indian students. (*22*) Some years ago this university instituted special counseling and social services for Indians. It was rewarded both by a large increase in the enrollment of Indian students, from 43 to 222 in the course of a few years, and by a large decrease in the dropout rate, from 56 percent to 17.

Prescription for the Schools

Other ways of helping the American Indian student achieve educational and vocational success, less by working on him than by working on the school system, are offered by a University of Denver psychologist who has studied alienation and achievement among the Oglala Sioux secondary school students. (*23*) These are among his conclusions and recommendations.

- Courses and programs in Indian culture, history, and heritage seem desirable not only in schools with a large number of Indian pupils but also in white schools in the same areas and to some degree in schools throughout the nation.
- In schools for Indians, formal teaching of the local Indian language should be undertaken in the interest both of preserving something inherently valuable and of trying to reduce alienation. Also, serious consideration should be given to the programs for teaching local Indian languages to teachers. "If Indian children are to learn English, it is not asking too much for their teachers to comprehend a native tongue. In fact, it might be a most exciting and broadening experience."
- Teachers of Indian children are likely to benefit from training in behavior management principles and so in the long run are their children. The goal is to improve the student's behavior and academic performance, which are often poor simply because of the teacher's tendency to expect

only a poor performance by children from lower-class and minority ethnic-group backgrounds.

- Preschool programs are needed to help reduce the frustration and anguish of children who are ill-prepared to cope with the usual material offered in first grade.
- Most Indian adults, as well as children, have positive attitudes toward education and the schools but feel that the schools have made little attempt to communicate with them, let alone give them any role in the school system. Further, since the history of white-Indian relations has been one of dominance-submission, passive resistance to white-directed efforts to improve the status of Indian groups is common. The first step toward improving this situation is to open communications between school personnel and parents as equals. A program of teacher visits to parents should be started under the guidance of both the schools and the Indian community, and this community should be given a more active role in the formulation of educational policy.

The Decisionmaking Process

Of particular concern to many social scientists is the way in which minority groups become involved, or fail to become involved, in the policy decisions that critically affect their way of life and their ability to participate in the country's sociopolitical system. For more information on this subject, a research team is studying those influences in Indian social systems, both traditional and present, which inhibit or advance the decisionmaking process. (*24*) The study, dealing with the Sioux community of South Dakota, is analyzing the course taken in settling several problems that were the subject of community conflict. The investigators believe that the findings will provide basic materials for educational programs—for example, through the civics courses in Indian schools.

Understanding Indian Medical Concepts

A research project concerned with Navajo medical terms and concepts has had important practical payoffs, starting with the publication of "Anatomical Atlas of the Navajo." (*25*) This work, with illustrations in color, includes an index in both Navajo and English and etymological and other lexicographic information about Navajo anatomical terms. Among other payoffs have been an instructional aide pamphlet ("The Way of Planning Births"), a children's reader ("What's Inside of Me"), and a health program based on Navajo cultural patterns.

Work in progress, looking toward a dictionary of Navajo medical terms, includes a description of abstract Navajo moral-psychological expressions, an important undertaking for understanding

Navajo concepts of mental health. Another project is the analysis of six terms comprising the key Navajo concepts of personhood. These refer to the human body, the human intellect (thought), the soul, the spirit or character, the human capacity for speech, and the human ability to move about.

The research is expected to contribute significantly to better communication between the Navajo and the Federal health personnel who serve the Navajo area. Many Navajos know only their own language, and even those who are bilingual tend to lose their second language under such situations of stress as hospitalization. The materials being produced will serve educators and interpreters and help provide health personnel with an orientation to the Navajo culture. A training program for Indian medicine men to help perpetuate elements of this culture is described in Chapter VII.

Indians and Alcohol

American Indians are afflicted by high rates of alcoholism and alcohol-related problems. Little is known, however, about the nature of Indian drinking, except that it is widespread. Consequently the Institute has supported a number of studies of drinking behavior and of problems related to drinking—among the Northwest Coast Indians (*26*) and the Papago, (*27*) the Yavapai, (*28*) and the Navajo (*29* & *30*) Indians, all in Arizona.

It is generally held that heavy drinking among Indians developed as a response to the degradation of conquest by white men, to reservation life, and to inability to compete adequately in the modern world. One investigator, however, who has studied drinking and social pathology among several southwestern Indian tribes, has found evidence suggesting that different tribes drink in different ways. This in turn suggests that even in early times there may have been certain predispositions to drink and that these varied with the tribe as well as with the individual. From his work he observes also that levels of chronic drinking as measured by cirrhosis of the liver do not always correspond to the levels of public or violent drinking; that increased consumption of alcohol does not appear to be associated with increased rates of crimes of violence; that crimes of violence in a given tribe appear to conform to patterns discerned in the aboriginal period; and that heavy drinking does not appear to be triggered primarily by experience in the armed services or by stays in boarding schools as much as by modes of drinking learned early by the individual Indian in his group.

As a further check, this investigator is making an anthropological study of drinking patterns in four communities of Yavapai

Indians. (*28*) The work is important because if a principal cause of Indian problem-drinking is indeed different from what has been supposed, treatment may have to be different, too.

Another study compared the drinking problems of Navajo wage earners in Tuba City, Arizona, and those of a typical kin-group living in the traditional manner in a rural area. (*29*) The diagnosis of cirrhosis of the liver and the number of deaths from cirrhosis were used as an indication of alcoholism. The mortality rates from cirrhosis were found to be lower in the rural areas than in the city, where access to alcohol is easier. More divorced, separated, or single persons—particularly men—became cirrhotic. Indian arrests for offenses associated with alcohol were seven times that for Americans as a whole. Suicide related to the use of alcohol was on the increase.

A treatment and research project studied 120 Navajo alcoholics—individuals who had been arrested for drunkenness and then placed on probation for 18 months so they could participate in this program. (*30*) After hospitalization, the participants were administered antabuse, a drug that causes nausea if alcohol is taken, and given psychiatric counseling. Among preliminary findings:

- Navajos who are trying to assimilate white middle-class culture are the most difficult to cure.
- Probation works well, probably because of the high value Navajo culture places on keeping one's word.
- Antabuse in daily doses was effective in some cases not only because of its inherent qualities but also because the tribe considered its use to be a healing ritual.

A special alcoholism program for Indians in which NIMH collaborates with a number of other Federal agencies is described in Chapter III; a program to train Indians, formerly alcoholics, to combat alcoholism on Indian reservations, in Chapter VII.

Studies of Rural Delinquents

There is a widespread belief that teenagers reared in rural settings are less inclined to be delinquent than urban youth. To determine if this is so and to identify and contrast the nature of the offenses committed by rural and urban delinquents, several studies have been funded by the Institute. One of these, being conducted by personnel of the Institute for Social Research at Ann Arbor, Michigan, is designed to validate measures of delinquent behavior among a set of teenagers in rural Michigan. (*31*) Since differences in delinquency rates may be traced to different methods of handling and recording rural juvenile offenses, this study should lead to more reliable comparisons between rural and urban reports. It should also increase our ability to find relationships between delinquency and a number of factors important in an adolescent's life—for example, relationships with parents and other teenagers. At present there is no systematic evidence linking family or peer relationships in rural life to delinquency.

School Failure Linked to Lawbreaking

Evidence that achievement in school—much more than social origins—helps determine whether or not a youngster will become delinquent is presented by a research team that has been studying several hundred rural boys as they move from midadolescence at 15 toward young adulthood at 24. (*32*) The investigators are particularly interested in "maturational reform," defined as the remission of delinquency and rebellion that often occurs as adolescents move into adult life. They are trying to identify those conditions and characteristics that describe and predict the nature of adolescence—either normal or especially troublesome—and the patterns of transition into adult roles. When the study began in 1966, under the direction of a University of Oregon sociologist, the youths were all sophomores in the high schools of an Oregon county.

The project has found that changes in grades, whether up or down, between the sophomore and the senior years are associated with both qualitative and quantitative differences in self-reported delinquencies. Youths whose grades had gone down reported an average of about 20 percent more delinquency than those whose grades had not changed; youths whose grades had gone up, an average of 20 percent less delinquency.

No significant relationship has been found between social origins and delinquency, and only small relationships between social origins and patterns of school success.

To the research team, such results demonstrate the overwhelming position occupied in the world of adolescents by the formal grading system. What leads to rebellion and delinquency, the team found, is the immediately experienced stigma of academic failure, as interpreted within the status system of the school.

The investigators believe that delinquency can be charged to the educational failure of schools as well as of students. They report that adolescent lawbreaking, a disproportionately large share of the total, is related to socialization processes that make it difficult for the young person to develop through legitimate pursuits, feelings of competence, usefulness, belongingness, and power—feelings that the adult can develop through his work and his community activities. "Given the organizational logic of the school, which creates 'dull' youth by identifying and differentially processing 'bright' ones," the researchers argue, "it is inevitable that an unsupportive school environment and dismal economic prospects will combine to encourage some failing youth to seek other routes to valued goals."

Among the work under way by this project is a study of the relationship between, on the one hand, delinquency and labeling and stigmatizing by the police, courts, and schools and, on the other hand, later criminal "retreatist" responses.

Studies of Rural Suicide Rates

The generally held assumption that suicide rates are higher in urban than in rural areas has been questioned in a number of studies. In 1968 the Institute funded the first statewide study to define the characteristics of the suicide and identify the high-risk suicide group in a predominantly small town and rural State. The project was undertaken by the Department of Health and Welfare of New Hampshire, which is mainly rural but nonfarm. (*33*) This State in 1964 had the seventh highest suicide rate in the Nation—14.8 suicides per 100,000 population.

Information for the study came from the death certificates of suicides over a 10-year period and from psychological autopsies—interviews with relatives, friends, co-workers, physicians, clergymen, and others acquainted with the suicide.

Regional suicide rates are very closely associated with the percentages of people identified as the "untreated mentally ill." This does not mean, by itself, that suicidal persons are mentally ill. But high rates of mental illness and of suicide seem to occur together and in areas that are either declining or growing slowly—not in places that are developing rapidly. In New Hampshire the high suicide and mental illness regions were found to have low population densities, with little effectual social organization in the community and few significant social ties among the people.

Data for the period 1955–1967 showed the following:

- Suicide rates are generally higher in rural than urban areas.
- More men, in all age categories, commit suicide than women—men over 65 having the highest rate.
- Poorer counties, being less heavily settled, grow more slowly, have a higher proportion of older men, and a higher suicide rate.

As a group, suicides seem to have severe problems with drinking, family, work, sex, nonfamily persons, drugs, and fears of illness and death—singly or in a combination. Some have had previous psychiatric treatment and have made previous attempts at suicide. They may express tiredness with life.

In a comparison study of those who attempt suicide and those who only think of it, certain social and psychological differences between the two groups were noted:

- The attempters are younger than the thinkers.
- Thinkers tend to be married; attempters to be single—either separated, widowed, or divorced.
- Thinkers tend to come from a rural population, the attempters from an urban area.
- Attempters have a higher family income and are more mobile residents; they are unhappy because they feel they have not reached a standard of living comparable to their parents'.
- Thinkers have much stronger family ties than attempters. They tend to live in the same town as their relatives and seem to feel more strongly than the attempters that they can confide in them.
- Attempters report they will actively try to remedy their difficulties; thinkers express more passivity.
- Attempters interact more with friends but tend to be less positively oriented toward others. They are more actively involved in the solution of their problems but have a more dismal view of the future.

In this study it was the family physician to whom most suicidal persons turned for help—the percentages running as follows: 71.8 percent to the family physician, 17.9 percent to a psychiatrist, 7.7 percent to a social agency, 2.6 percent to a clergyman. Of 50 New Hampshire suicide victims, 72 percent had seen a physician within 3 months of their deaths and 62 percent within 30 days. Eighteen percent committed suicide within 24 hours after seeing a physician.

Unfortunately, when the suicidal patient consults the doctor, he seldom admits that he contemplates taking his life; he does not give, as the reason for his visit, the depression, anxiety, marital and financial problems, special needs, and psychological illness he has been experiencing. Unable to express his suicidal ruminations, he hopes the physician will suspect his intentions and ask him about his thoughts. When a physician sees an unusually anxious patient, he should be on the alert and ask him if he ever considers taking his life, for the patient has an intense need to communicate with another human being to whom he can unburden himself.

Certain interesting relationships between mental illness and suicide were observed:

- Both the number of admissions to the State hospital and the number of suicides rise during the month of March and reach a peak in May.

- Both admissions and suicides decrease in June and remain low through July.
- Admissions peak again in August, and suicides in October. Admissions decrease after August and suicides decrease in November. Suicides rise in December and admissions in January.
- Both suicides and admissions are low in February.

Seasonal patterns of mental hospital admissions have been found to be very similar year after year. More remarkable, the admissions pattern recorded in two French hospitals in the mid-1800's was almost identical with that at the New Hampshire Hospital a century later.

Another project, "Rural-Urban Differences in Suicide Rates," begun in 1969 at the University of Georgia, (*28*) finds that:

- Suicide rates for rural male residents are twice those for urban males. In the older age brackets, the highest rates of suicide are found among farmers.
- The majority of rural white male suicides have been engaged in occupations characteristic of an urban group; they have lived in the country but have been urban-oriented in terms of occupation and mental attitude.

This is a nationwide study to provide a uniform baseline of suicide data so that comparisons can be made through time and between places. The information it is providing and that from the New Hampshire study are valuable in the establishment and effective operation of suicide-prevention services.

Healing is a matter of time,
but it is sometimes also a
matter of opportunity.
—Hippocrates

CHAPTER III

NEW APPROACHES TO RURAL MENTAL HEALTH SERVICE

The National Institute of Mental Health has supported numerous research demonstration projects to explore ways of alleviating the mental health service crisis in rural America. The projects can be placed in two broad but overlapping categories. The first includes efforts that focus on closing the gap between the State mental hospital and the community; the second, efforts to mobilize and strengthen whatever mental health resources may already exist in rural areas. Examples of both categories are presented in this chapter. They suggest how communities and States can improve mental health services through relatively simple measures whether or not the community mental health center approach —described in Chapter IV—has yet been adopted. As it happens, some of the projects have been carried out with the help of a center, and some others have paved the way to a center.

Closing the Gap Between Hospital and Community

Because of the gap that usually exists between therapeutic endeavors at the State hospital and those in the community, the patient returning to the community is often confronted not only with a lack of understanding but also at times with prejudice and fear. Without an adequate followup program to guide him and to help change hostile attitudes, the efforts of the returning patient to rehabilitate himself often fail, and he finds himself back in the hospital.

Providing Aftercare Services

Evidence of the value of supportive services comes from a number of projects. One of these, administered by the Department of Mental Health of Oklahoma, used an NIMH grant to establish programs in four communities—one rural, one semi-rural, and two urban—under the immediate direction of social workers residing in the communities. (*35*) Later these four programs served as models for programs funded by the State in other communities. The project's general aims included provision of services for returning patients and coordination and expansion of existing community resources in behalf of such patients.

People returning from the hospital, it was found, commonly experience crisis periods. Among the problems with which former patients needed help were the cost of medicine, limited supervision of the use of medicine, lack of transportation to the sources of help, lack of employment and training opportunities, problems related to living arrangements, and inability to get along well socially. The teenager, the young adult, and the elderly patient were all found to have special problems. Social work intervention during the first two weeks of a person's return from the hospital was considered crucial.

About 200 patients included in the four programs were compared to a group that had not been included. Among the patients not included, a little more than 50 percent returned to the hospital at least once during the course of a year. Among those in the program, the rate of return was 32 percent.

In Kansas an Institute-financed project known as the Mid-Kansas Rural Aftercare Demonstration found evidence both of the value of followup services for patients treated in a State hospital and of the usefulness of community mental health centers in arranging for these services. (*36*) Directed by the Prairie View Mental Health Center at Newton, Kansas, the project set out to improve services for persons returning to three rural counties after a stay at Topeka State Hospital. It developed a program based on integrating the efforts of existing resources and filling in any gaps. Emphasis was placed on low-cost service through the use of minimal contact clinics, referrals to existing agencies, group approaches, and the investment of a minimum of mental health worker time.

As evidence of the project's success, the percentage of readmissions to the State hospital was significantly lower in the tri-county area where the aftercare services were provided than in the rest of the State. Patients who received aftercare services did not show a great deal of improvement in individual adjustment, but more of them—as compared to a group that did not receive such services—were able to assume productive roles and to remain in the community.

Several specific aspects of the venture appeared to contribute directly to the provision of more adequate services. Regular communications between Topeka State Hospital and Prairie View staff were developed and maintained. The planning of aftercare treatment with patients before their discharge was increased. The mental health center took the initiative—it was obliged to do so—in getting in touch with persons referred for aftercare services. Flexibility was ensured through the provision of individual or group therapy, partial hospitalization, sheltered workshop experience, and occupational therapy. One or all of these were used as needed. Community resources were mobilized by establishing "resource councils" to provide monthly forums for county health and welfare agencies and by developing consultation relationships with personnel from local industry and schools.

The service delivery activities developed during the course of the project have been integrated into the clinical service functions at Prairie View Mental Health Center. Mental health center boards have assumed responsibility for the expenses of the visiting nurse and the minimal contact clinics, and are also financing community resource councils throughout the tri-county area. The liaison responsibility between Prairie View and the State hospital at Topeka is being carried financially by both, and monthly meetings are alternated between these two facilities. Chapter V includes a discussion of other activities of the Prairie View Center.

Improving the Attitudes of Family and Community

A project in rural Arkansas grew from the recognition that the health and stability of a returning patient cannot be maintained solely through his own efforts but depend to an important extent on the attitudes and actions of persons in his environment. (*37*) The family, even the most inadequate one, is the most important source of support. So it is vital that the families of former patients be helped to accept, not reject; to understand, not fear; to support, not reproach.

This project, administered by the State hospital at Little Rock, covered seven geographical areas. In each of these, social workers who had been trained in group educational methods led discussions attended by interested relatives of patients newly released from the hospital. Each group held a number of meetings, during which the relatives discussed their problems and were given help in meeting them. Psychiatric personnel at the hospital helped recruit relatives for these meetings; project staff members arranged with local health and welfare officials to make their resources available to the members of the groups; and, before the meetings began, leaders of the groups established contact with key professionals and laymen in the areas.

The project soon found that a gap existed between patient and community as well as between patient and family. Since many of the patients were clients of community agencies, the project expanded the group discussions to include key personnel of these agencies. In two years, 19 groups met in 15 different communities.

The payoff has been not only improvement in the attitudes of family and community but also the establishment of aftercare or other types of mental health service in many of the communities. The number of Arkansas counties having aftercare services increased in two years from 5 to 53, in many cases because the program workers helped community leaders to see and meet the need for new services. As another result of the program, counselling groups have been formed for mothers of mentally retarded, cerebral palsied, and other handicapped children.

Arkansas communities no longer look to the State hospital as the sole provider of psychiatric treatment, drug maintenance, and outpatient and aftercare programs. Now, many can provide these services with assistance from the hospital, the Mental Health Authority, and other State and local agencies. The change can be attributed in part to the work of the project personnel and the demands for home-based services from relatives who participated in the group discussions.

Reaching Remote Areas Through a Team From the Hospital

Though many rural people live near larger towns or cities and can receive some mental health services there, some of those most in need of such services live in remote areas beyond the reach of the usual mental health program and too distant from the State hospital to make much use of aftercare services as usually provided. Evidence that even these isolated areas can be served has been offered by an Institute-supported project in the mountains of eastern Kentucky. This region is among the poorest areas in America and until recently was one of the most isolated. Yet the superintendent and the director of social services at the nearest State hospital—then five hours away—developed a program with the aid of an NIMH grant that took psychiatric services to the hills and the hollows and into the dim rooms of weathered cabins to reach former patients and others in need of diagnostic and treatment services.

The hospital, Eastern State, serves a large area that includes four Appalachian counties, those farthest from the hospital. Before the program started, patients from those counties stayed longer in the State hospital and were readmitted more frequently than patients from the rest of the service area. The only local psychiatric resource was a clinic for former patients that was held for two or three days a month in the region's largest community, Pikeville. The clinic team comprised a psychiatrist, a social worker, and sometimes a psychologist, all from the hospital. Three years after its opening the clinic was trying to cope with a caseload of 200. At this point the hospital undertook its Institute-financed project to test the idea that admissions from the mountain counties would be significantly reduced if a two-man clinical team—a psychiatric social worker and a psychiatric nurse—were stationed in the area fulltime (*38*) to give help to former patients and to other people who might need it. There was the hope, too, that the team could help the region develop its own mental health resources.

Efforts at the start were centered on people who had been hospitalized. Through letters, phone calls, and home visits, the team tried to get and stay in touch with those the hospital considered especially likely to need aftercare. The aim was to prevent crises that might lead to rehospitalization. The team members worked by offering immediate counsel to former patients and their families, enlisting community resources in their behalf, and encouraging attendance at the monthly clinic still being given in Pikeville by staff people from Eastern State Hospital, assisted now by the project team. In July of the project's first year, appointments for this clinic numbered 150; 6 months later, 227. As word spread that professional mental health people were available, more and more of the caseload comprised persons who had never been hospitalized. Eventually these constituted about 50 percent of the total.

Members of the project sometimes achieved results simply by the application of common sense. One elderly man's family, for example, worried because he was forever leaving the yard, wandering down the road, and getting lost. The family asked for help in having him committed to the State hospital. Instead of helping in that respect, the social worker suggested that the family build a fence around the yard. They did, and the old man remained contentedly at home. A number of other senile persons who would otherwise have gone to the State hospital for the rest of their lives were placed in nursing or foster homes.

Individuals connected with the project are particularly proud of their work with persons arrested for drunkenness. The team members, through their acquaintance with the jailer and his wife, would take a jailed alcoholic to the county health department for tranquilizers and then talk with him, often repeatedly, in the jailer's quarters. Eventually the jailer and his wife took the initiative in handling such cases. A number of the alcoholics reached in this way stayed dry. One of them won election to the State legislature.

Eight months after the work began, one of the investigators wrote:

> The most significant development since the team started is the involvement of local individuals in the handling and treatment of psychiatric cases. In the past, almost everyone from the circuit judge to the private physician only dealt with a "mental case" when there was an acute emergency and then always took the line of least resistance. It was not unusual for a disturbed person to spend a week or more in the local jail waiting to be committed and transported to the hospital. The local physicians found it very difficult to involve themselves in these cases. However, now that the community has professional mental health leadership, most of the doctors are quite willing to give their time and service.

Travel required an extraordinary amount of time. When even four home visits could be made before sundown, it was a good day. Some homes deep in the hollows could be reached only in a four-wheel-drive car. There was so much to do in Pike County, which accounted for half of the region both in area and in population, that team members rarely visited the other three counties. The team did schedule patients from the entire region for the Pikeville clinic and during the second year began holding monthly clinics in each of the other three counties. At these clinics the county health officer, a general practitioner, served as the medical consultant. During the second year, team members saw more than 625 different patients having a wide variety of problems—ranging from marital trouble to schizophrenia—and conducted more than 2,500 interviews.

The results were almost startling. After 2 years, the rate of readmissions to the State hospital from the four counties had dropped 67 percent. And the first admission rate from Pike County, where the team members lived and did most of their work dropped 40 percent.

Another outcome was even more important. During the second year of the project, the Mountain Mental Health Association, limited to Pike County, was formed, and membership reached 500. This made the association the largest of its kind in the State. Members of the demonstration team served the group both as advisors and fellow workers. During the project's third year, a regional mental health board was set up to organize and operate a community mental health center. From a once-a-month "pill clinic" in one county for former State hospital patients, the mental health services in this region of Appalachia have grown to a center that provides full-time services in each of five counties. Additional information about this center in the Appalachians of eastern Kentucky is contained in Chapter V.

Mobilizing and Strengthening Community Resources

In providing adequate mental health services to rural people, an even more serious problem than distance is the extreme scarcity of mental health professionals. Institute-supported studies are demonstrating that this problem can be met in a number of ways, all of them having one important factor in common—the more effective use of resources that may already be available.

Testing a New Pattern of Service

A novel plan under trial in North Carolina is an example both of efforts to employ local resources more effectively and of efforts to close the gap between the State hospital and the community, the approach discussed in the preceding section. (*39*)

Several years ago a North Carolina study of mental health needs and resources, conducted under an Institute planning grant to the State's Department of Mental Health, found an urgent need to develop new patterns of service to rural areas. The Department's planning staff recommended that the effort focus first on services to families and children. A family-child program, it was pointed out, could become a means of mobilizing community support for a comprehensive mental health center. The present project is a test of a program intended to meet that recommendation.

In a preliminary phase, members of the Community Psychiatry staff at the University of North Carolina went to two nearby counties, noted the meagerness of the mental health services, and surveyed attitudes toward an increase in services. As reported earlier, almost everybody hoped for something more. Project personnel then helped community leaders to organize a mental health authority in each county to work with the university in setting up a preliminary rural mental health unit—a Family Counseling and Education Center.

The key people in each county's setup are the program coordinator and the "service guide," who maintains liaison between the community and the nearest State hospital and also helps families find needed services within the counties whenever possible. None of the key people had experience in mental health programs, but all were long-time, well-known residents of the area. One of the program coordinators is a woman with a bachelor's degree in home economics; the other, a man with a master's degree in education and experience as a high school principal. In one county the service guide is a man who had worked for the Department of Agriculture as a land surveyor. The other county, mainly because of a death and a transfer, has had a succession of guides, including a former captain of detectives in a police department, described as a man with little formal education but an unusual amount of social intelligence, a minister, and a former gas station manager.

Also on the staff of the Family Counseling and Education Centers are a child psychiatrist, a nurse, and a social worker, all of whom serve part time, and residents in psychiatry and psychology at the University's Psychiatric Center, who visit the community once a week. Psychiatrists and other members of program development teams from the university also go to each county weekly or more often to work with the centers' staffs, with care-taking agencies and individuals, and when necessary with patients. Arrangements have been made with local physicians to provide emergency services.

The project's main goal has been to mobilize the resources already present, strengthen them with educational and consultative services, and thus develop the community's ability to help itself. The program team has kept in mind the findings reported in Chapter II, including the especially great need for help among those poor in education and income. In a further effort to provide the services most needed, the program coordinators met with citizen advisory groups early during the project to get their ideas about problems and needs.

As one result of the meetings with advisory groups, the centers initiated a weekly "information exchange"—a walk-in, no-names-taken meeting—for the discussion of everyday problems of living. Problems submitted are listed on the blackboard, and the group discusses "common sense" management of them. Project directors point out that the meetings deal with the mild and moderate problems of living and are no substitute for clinical services.

Other services have included parents' groups for guidance on child behavior; personality development workshops; group meetings for unmarried mothers; high school discussion groups on the general theme, "Youth Talks It Over"; a child clinic one evening a week; psychiatric services for the elderly one day a week; screening, therapeutic, and educational services by a psychiatric nurse two days a week; a medication program, through local drugstores; and precare and aftercare services for persons who need to be hospitalized.

The project has also helped to establish "older tutor younger" programs through the schools serving two low-income areas. Under these programs, fifth and sixth graders beginning to fail in school are prepared to go into poor backwoods homes to motivate and tutor young children whose school progress has been poor—and in the process to become remotivated themselves toward success in school.

Among the services intended to reach the especially vulnerable groups through individuals and agencies already in touch with them have been a monthly consultation period with public health nurses on emotional problems they encounter; a monthly conference with clergymen and the employment of a marriage counseling consultant to serve all the churches; workshops for teachers on classroom behavior problems; a series of inservice training sessions for the nursing staff of the general hospital; and bimonthly group consultations with welfare workers.

Most of the project's educational efforts, it reports, "have been directed toward understanding the 'normal problems of living' as reactions to stress or results of deprivation of basic emotional needs. Major mental illnesses have then been portrayed as severe reactions understandable in the same terms. Staffs have formed the operating hypothesis that increased tolerance and understanding of major illness will follow developing understanding of minor emotional problems."

To discuss problems of mental illness and attitudes toward them, and to encourage citizen recommendations for solutions, Neighborhood Citizens Councils have been meeting at the centers and in churches, schools, and homes. More than 100 such groups, with from eight to 15 persons in each, have been involved.

When grant support of the centers ended in 1971, the two counties provided the additional funds needed to keep them running. In the near future, it is expected that these preliminary rural mental health units will become the nucleus of a comprehensive center, offering complete clinical services in addition to present programs and serving five counties. Meanwhile, the investigators are again analyzing the mental health status and attitudes of the people in the two counties and of those in a neighboring control county. The findings will be compared to those of the first survey, before the centers were established. It may be that they will encourage other rural counties to undertake programs generally similar to the one sketched here.

Developing Services With the Help of Consultants

To strengthen local resources, the New Mexico Department of Public Health, under a 5-year demonstration grant, deployed half a dozen district mental health consultants through the State to provide case consultation to health, welfare, education, and law enforcement agencies and to doctors, lawyers, and clergymen. (*40*) The consultants, who were psychologists, social workers, or mental health nurses, also helped agencies provide inservice training to their staffs and worked to assist communities in developing mental health services according to their needs and resources. Consultants covered an average of five counties each.

Initiated during the demonstration period were a day school for retarded children, a day center for emotionally disturbed children, and organizations of parents of such children; a family casework agency; and citizens' organizations for planning and supporting local mental health services.

At the end of the demonstration, the State used it as a model for other projects. Indirectly, the demonstration also helped lead to the community mental health center at Las Cruces, which serves a large rural area.

Psychiatric Consultation by TV

Sullivan County, New Hampshire, has no psychiatrist but it does have 21 practicing physicians. And the rural physician, because he knows his families well and is often the first person called upon in time of trouble, is in an excellent position to provide early psychiatric help. The presence of a medical college within the State is another resource. The combination of these resources in an Institute-supported demonstration has provided the residents of the area with psychiatric consultation by television. (*41*)

The TV setup is a closed circuit, two-way, two-channel microwave system between the general hospital in Claremont, Sullivan County, and the department of psychiatry at the Dartmouth Medical School, Hanover. It is available day and night. The service is limited to adolescents at least 16 years old, and adults. A physician in Sullivan County, desiring consultation, calls a psychiatrist at Dartmouth. A mutually convenient time is set and the physician and patient go to the hospital studio in Claremont, where they can see and talk with the psychiatrist in Hanover. After the psychiatrist has interviewed the patient, the two doctors confer. The emphasis is on helping the physician maintain the patient under his care at home. When hospitalization is required, the patient is admitted to Claremont General, if at all possible.

In a 1-year period there were 199 consultations, of which 142 concerned new patients and the rest were followups. Most of the consultations have been initiated by general practitioners, but an internist and a surgeon have also used the service extensively, and the mental health clinic in Claremont, staffed by a social worker and two psychologists, initiated 45 cases.

As hoped, the trend has been to seek consultation on the less seriously affected patients and those in the early stages of the disorders. Sixty percent of the patients had never had psychiatric care. Less than half were diagnosed as psychotic.

Television has been found a good medium for psychiatric consultation. The patients have accepted it; the procedure has not produced additional anxiety, even in paranoid patients; the reactions of physicians have in general been highly favorable; and the psychiatrists have valued the wealth of information and the insights offered by the rural family physician. TV lunch conferences were developed to expand the opportunity for general discussions. The group in charge of the project has received a grant from elsewhere to extend the service to other rural counties in New Hampshire and the rest of New England.

Nurses as Crisis Counselors

A program in Vermont demonstrated the value of a different community resource—nurses—in strengthening mental health services for rural people. (*42*) The program was developed by a psychiatrist at the University of Vermont who for 10 years had been a general practitioner in a rural county. He had been impressed during those years by the number of times people in trouble turned first to a nurse. As a psychiatrist he wondered if the need for more trained mental health manpower could not be met to an important extent by making better use of those who were already trying to deal with individual and family crises and thus to prevent possible mental illness. Wouldn't it make sense, he asked, to identify people who were natural crisis-interveners, train them in the newest psychiatric concepts, acquaint them with the available resources, and thus enhance their ability to deal with emotional problems and prevent maladaptive solutions?

In the resulting program, more than 100 authorities in three rural counties—clergymen, hospital administrators, overseers of the poor, welfare workers, lawyers, and physicians—were asked for the names of nurses to whom people turned spontaneously for help. Thirty-five women who were listed most often were then invited to join the program. All of them accepted. Eight other women were also invited—and they accepted—in case of dropouts. There were none.

The nurses ranged in age from the early twenties to the late fifties. Almost all of them were married and had children. The great majority also held full- or part-time jobs in hospitals, nursing homes, school systems and other governmental agencies, or as private duty nurses. All of them, even the few who had retired from nursing work of any kind, had reputations as individuals to whom other persons kept turning in time of trouble.

For each of three groups, classes were held 2 hours a night, 1 night a week for 26 weeks. Through lectures, discussions, case material, and assigned reading, the nurses became acquainted with crisis theory and with methods of helping individuals and families to meet crises and thus became strengthened to meet future crises. A number of meetings explored psychopathology, with emphasis on early signs of mental and emotional distress. To throw more light on normal and abnormal behavior, another session dealt with the maturational crises to be expected as an individual passes through the various stages of life. With the help of psychodrama in which the nurses participated, one meeting emphasized the importance of recognizing the roles, tensions, and relationships of persons involved in a crisis. Other meetings dealt with alcoholism, drug addiction, and mental retardation. Films explaining types of mental illness and effective ways of interviewing and counseling a troubled person and his family were shown and discussed.

To make the nurses aware of the resources open to people in crisis, representatives from such State agencies as Social Welfare, Alcoholic Rehabilitation, Vocational Rehabilitation, and Probation and Parole attended meetings and described the services offered. Toward the end of each course, the medical or executive director of the local mental health service explained the structure and function of his agency and the procedure to be followed in referring somebody for evaluation and therapy. And he urged the nurses to apply for consultation at any hour. The resulting closer relationship between nurses and local mental health services is considered one of the project's more important results.

At the end of the course the nurses were certified as community crisis counselors. For a long period they met each month to discuss with various professionals how to meet problems the nurses had encountered.

The directors of this experiment feel that the nurses have become more tolerant and objective—more ready to view a troubled person as someone who may be helped if approached with an open mind. The nurses themselves are sure of the program's worth. "Many times problems would come up on the job, or outside it," a public health nurse reports, "that I wasn't quite sure what to do with. Was it all right for me to handle them myself? Would it be better to refer them—and if so, what was the best place? I can answer these questions more easily now."

To a woman who works part-time with a social agency, the one most beneficial session was that which dealt with disturbed children. "When I went to school 15 years ago," she recalls, "the time allotted for psychiatric problems was given almost exclusively to the handling of psychotics. But as a nurse, people rarely ask me to handle a psychotic; they do often ask me what to do about a child with behavior problems."

As the result of their training, the counselors have successfully dealt with many emergencies, including a number of cases of attempted suicide. Though the crisis interveners rarely solved a problem all by themselves, they rendered emotional first aid and checked to see that any recommended additional treatment was carried out. The project's goal was to increase not the number of people served but the competence of the nurses serving them. Nevertheless, some of the nurses report that they are helping more people as well as helping them more effectively.

The director of the program thinks that it has won a favorable response in Vermont and has drawn inquiries from a number of other States because it uses talents already in the community, does not require large expenditures, and brings good mental health care to persons who probably would not otherwise receive it.

Using Other "Natural Helpers"

In the small town of Holton, Kansas, a project financed by the Institute has demonstrated that older people, too, are a community resource. They can be mobilized to help others and, in the process of doing so, benefit themselves. (*43*)

The venture is known as the Neighbors United Project. It is directed by an executive board chosen from the membership of 14 highly community-oriented organizations. The board, most of whose members are elderly, identified and rated community needs and drew up plans for action.

Many older people seized the opportunity to assume a community participant role and undertake activities—such as counseling, friendly visiting, a Head Start program, and community beautification—in service to others. When Institute support ended, Neighbors United was continued under local auspices.

A second, newer project in this rural area seeks to use and enhance the skills and potentials of all the community's "natural helpers"—those individuals, often including the grocer and the druggist, to whom people frequently turn for help—and "indigenous counselors," such as clergymen and nurses. (*44*) A survey found that many residents felt in need of counseling on personality disorders, behavior problems, parent-child interactions, marital troubles, and financial problems. The need is being met in part by the "natural" helpers and counselors of the community. What the project hopes to do is increase both the extent to which these individuals are being used and, through collaboration with professionals, their ability to function effectively. The Neighbors United Board is helping to mobilize local resources for this project.

Mobilizing Indian Resources Against Alcoholism

An Indian Health Service Task Force on Alcoholism stated in 1969 that "the majority of suicides, murders, accidental deaths, and injuries are associated with excessive drinking, as are many cases of infection, sclerosis, and malnutrition. By far, the majority of arrests, fines, and imprisonments are the result of drinking (76 percent)." To meet the need for services related to alcohol abuse and alcoholism, NIMH developed a collaborative program with the Indian Health Service, Health Services and Mental Health Administration, the Bureau of Indian Affairs (Interior), the Office of Economic Opportunity, the Social Rehabilitation Service, and the Office of the Secretary, Department of Health, Education and Welfare. The program provides funds through contracts with Indian groups to enable them to implement their own program of services to their population. In most cases funds are being used to provide a staff of alcoholism counselors who serve the reservation population or Indians living in rural areas with a concentrated Indian population. Tribal programs are under way by the Laguna-Pueblo Tribe in New Mexico; the Intra-Tribal Alcoholism Treatment Center at Fort Sheridan, Wyoming; the Hualapai tribe in Peach Springs, Arizona; the North Central Inter-Tribal Council in Pawnee, Oklahoma; and the Rosebud-Sioux and Cheyenne River Sioux in South Dakota. Programs to serve Indians who are not living on reservations are underway in communities of Oklahoma by the Anadarko Committee of Concern; in Sioux City, Iowa, and the surrounding region by the American Indian Council on Problem Drinking; and in Anchorage, Alaska, and the Aleutian chain by the Aleut League of Anchorage. In addition, the Institute has a contract with the United Southeastern Tribes of Sarasota, Florida which is enabling them to conduct tribal conferences for the development of an alcoholism action program for each tribe—Seminole, Choctaw, Seneca, and Miccosukee. And, a contract with the Student Council and Parent Advisory Board of the Chemawa Boarding School in Chemawa, Oregon, is enabling students and parents to develop their own alcohol education and alcohol abuse treatment program for the school.

As part of the New Mental Health Careers Program, a project in Montana—described in Chapter VII—is preparing former Indian alcoholics to work on their own reservations against problems of alcohol.

There can be no question that the community mental health center movement serves at the very heart, the very center, of the most dramatic and most cogent issues of contemporary life. It operates amid a turbulent social scene nationally and locally. The price of our being there is high but the rewards in terms of opportunity for service are great.

—Bertram S. Brown, M.D.

CHAPTER IV

COMMUNITY MENTAL HEALTH CENTERS IN RURAL AMERICA

The movement to establish and promote the growth of community mental health centers has given rural America—and, for that matter, all the rest of America—one of its most vital and dynamic health programs. The goal is to provide throughout the country comprehensive mental health services within easy reach of everyone who needs them. Each of the 50 States has submitted to the Institute and received approval of a plan for mental health centers that will serve every area—urban, suburban, and rural.

Historical Roots of the Program

For many years the only mental health facility available to the vast majority of rural Americans—and of urban as well—was the State mental hospital. Typically it was large and isolated and, in spite of its size, increasingly overcrowded. Instead of treatment, it offered custodial care. Many patients lived out their lives in it. A major departure from the public mental health hospital was the child guidance clinic, which sprang up as a result of the increased awareness that early treatment of emotionally disturbed children, and of their families, could prevent the development of more serious disorders later.

World War II drew fresh attention to the organization and delivery of mental health services. A surprisingly large number of American men were rejected for military service because of psychiatric disability and, among those accepted, a surprisingly large number became psychiatric casualties. At the same time, the military was able to demonstrate that long-term hospitalization was neither the only nor the most effective treatment for mental disorder. Through short-term hospitalization and a rapid return to the community—in this case the military community—psychiatric casualties were once more able to function effectively. Such demonstrations that psychiatric disorder was not irreversible helped to reduce the stigma attached to mental illness.

Against a background of growing public concern, Congress in 1955 passed the Mental Health Study Act. This led to a five-year analysis, by the Joint Commission on Mental Illness and Health, of the problems of mental illness and the possible solutions. One major conclusion was that both outpatient and inpatient facilities for treating the mentally ill should be available in the community.

On February 5, 1963, in a Special Message on Mental Illness and Mental Retardation, President Kennedy called for a "bold new approach" and proposed, as a key to this approach, the community mental health center. Congress responded by enacting the Mental Retardation Facilities and Community Mental Health Center Construction Act of 1963. This Act, with subsequent amendments, is making it possible for communities throughout the Nation to develop comprehensive mental health programs. Development may occur either through creation of new agencies or coordination and expansion of existing resources—both with the aid of grants from the National Institute of Mental Health.[1] Each community mental health center, serving a defined "catchment area," must make at least five basic services available—24-hour emergency care, short-term hospitalization, partial hospitalization, outpatient care, and programs of consultation and education. The goal is to make these services accessible to every resident.

Rural Mental Health Centers

The growth of the centers program has been rapid and its impact extensive. From the first grant in July 1965 to the end of fiscal year 1973, slightly more than 500 community health centers were funded, to serve areas with a population of 73 million. There are centers and their branches located in every State and in communities ranging from inner city ghettos to remote villages, from affluent suburbs to the very poorest counties of Appalachia. They are demonstrating that mental health services can be provided to all kinds of communities, even those in areas abysmally short both of money and other resources.

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[1] Federal funds for the construction of new centers are not available at present. See page 165.

Of the funded centers, slightly more than 200, or 40 percent of the total, are rural centers. That is, they were funded to serve one or more predominantly rural counties—those outside of Standard Metropolitan Statistical Areas in which more than half of the people live in communities of 2,500 or less. When the rural counties in Standard Metropolitan Statistical Areas are excluded, because they have access to the resources of a central city of 50,000 or more, 2,077 or two-thirds of all counties were rural in 1970. Close to a third of these counties and close to a third of all the people in such counties were in the service areas of community mental health centers by the end of fiscal year 1973.

Meeting Problems of Money

The statistics given for rural mental health centers constitute a record that is particularly impressive because of the serious problems inherent in the development of centers in rural areas. One problem, more severe in rural areas because they have a low tax base and because the delivery of services over a wide area is expensive, is money. Construction and staffing grants from NIMH fall far short of meeting all the costs. Construction projects have averaged, for all centers, $1,500,000, and Federal aid has covered on the average only about 30 percent of this. The cost of operating a center, as estimated by applicants for Federal assistance, runs to about $750,000 a year; no more than 40 percent of this—averaged over the 8 years of assistance permitted under present law—is covered by Federal funds for salaries. Matching funds must be provided both for building the center, if construction is required, and for paying staff salaries.

Many rural mental health centers have held construction costs down, sometimes to zero, by operating at least some of their services from rented or donated quarters in houses, hospitals, and other types of buildings. One center has headquarters in what used to be an apartment above an automobile showroom, and it has made the showroom into a daycare center. Another is housed in some of the barracks of a former Air Force base. Satellite centers have found quarters in such places as the parish house of a church, a community clubhouse, and a civil defense office. As for staffing expenses, the centers try to hold them down by making wide use of trained volunteers and nonprofessional workers.

The chief source of funds, after NIMH, is usually the State. Other sources are local taxes, gifts, and patients' fees, often paid at least in part by public or private insurance. In some cases, the people of rural townships or counties have voted a special tax to support a center. In some others, where approval of a new tax is considered highly unlikely at present, centers are trying to compile such a record of service that approval a few years from now, when Federal aid will have sharply declined, can be expected. Increasingly important sources of income for some centers are their mental health consultation and training services, particularly those developed for the schools. Rural school systems often lack such mental health personnel as guidance counselors, speech therapists, and psychologists, and many of their teachers lack training in identifying and helping children who have psychological problems. In a number of rural catchment areas, centers have contracted with boards of education to help correct these deficiencies. Examples are given in the next chapter.

Building a Staff

A second major problem is the lack of professional manpower. As noted earlier, a greatly disproportionate share of psychiatrists, psychologists, social workers, and other mental health personnel are located in urban areas. So the administrators of rural centers commonly have had to work hard to put together a basic staff. Many have advertised in professional journals and even in newspapers frankly and proudly describing their rural situation with such phrases as "a friendly rural county," "provides small-town living and is surrounded by first-rate scenic-recreational opportunities," and "in the heart of Appalachia." In addition to such advertising techniques, rural centers try to attract professional personnel by offering higher salaries than other centers more conveniently located.

Some centers have filled staff positions with relative ease, partly because their location attracted people who found urban life distasteful and partly because their directors could draw upon former associates. A center in Aroostook County, Maine, hired a complete staff within a few months. (*45*) And the director of a center in northern Wyoming reports: "The experts had predicted we would have a great deal of difficulty getting people to come here to live, but it just wasn't so. For example, we had 34 psychiatric social workers apply for one position that was open. We now have a staff of 13 people serving this area of 44,000. Seven of these people are full-time professionals." (*46*)

In most rural areas, however, the demand for psychiatrists and other mental health professionals far exceeds the supply. Centers in isolated or remote regions must be especially resourceful in recruiting and using personnel. For example, some centers—

including two reported upon later, in Kentucky and Vermont—have gone a year or more with only a part-time psychiatrist; they have made his services go a long way by using him primarily as a consultant to the other therapists on the staff.

Many centers make good use of indigenous nonprofessionals, assigning to them functions that used to be restricted to persons with formal professional training and degrees. These persons without a professional education are trained on the job to act as caseworkers, counselors, and even therapists. They are especially valuable because they give the professionals on the staff an understanding of the area and its people that they ordinarily do not have if new to the region. Additionally, they promote the use and acceptance of services provided by the center. Native mental health workers are particularly important to such a center as the one recently funded in northern Arizona, (*47*) which serves three Indian reservations in one urban and four rural counties, whose residents also include substantial numbers of Mexican-Americans and blacks. Another example is the center in Kingsville, Texas. (*48*) Most of the people in its predominantly Mexican-American catchment area view mental disorders as something to be hidden, not treated. But they can accept into their homes fellow Mexican-Americans who have been trained by the center both to help families solve their many problems and to provide education in mental health.

Personnel without a professional education—they are commonly called mental health workers or aides—have so proved their value that an increasing number of community and junior colleges are developing training programs for them. This is the case in Maine, for example, where one center has worked with the State university to develop a 2-year course leading to an Associate of Arts Degree in Mental Health Technology. (*49*) Many of the courses are taught by members of the center's staff, and some of the graduates are expected to be hired to broaden the center's services in outlying areas. NIMH, by supporting the first efforts in this direction, has largely been responsible for the development of such 2-year programs. More information on this phase of the Institute's training program is given in Chapter VII.

Another rural center in Maine is working with a branch of the university toward an even more basic approach to the problem of manpower for mental health and other services. (*45*) In this approach, students are helped to look at the many problems of their economically depressed area as a challenge—so fascinating a challenge that young people ought to take it up instead of, as many of them have been doing, accepting a challenge someplace else.

To carry out their mission with the manpower they can afford, rural centers often draw heavily upon other mental health resources their region may have, including volunteers. The name chosen for the mental health center in Boise, Idaho—submitted by a housewife in a contest—could be appropriately used by many other centers as well: "Community Institute of Human Resources." (*50*) Among the volunteers bolstering this center's staff are undergraduates from Boise State College; a beautician, who serves women in the daycare program once a week; an elderly housewife who accompanied a friend to the center and wound up, after a graduate-level course in group therapy techniques, as a group leader; several clergymen, who participate in group sessions, work with parents of children being treated at the center, and counsel married couples; and even some patients and former patients, one of whom has led a daycare class in music appreciation and another, a class in yoga.

The Problem of Distance

Another major problem is how to effectively and efficiently serve large, thinly settled catchment areas having little or no public transportation. While some rural centers cover only a few hundred square miles, one in Montana covers 46,000, and one in northern Arizona, 61,000. More than 30 centers serve areas of more than 5,000 square miles. Though NIMH suggests a catchment area population of between 75,000 and 200,000, it has made many exceptions. Among approved areas the range is from 16,000 persons to 240,000.

A common response to the problem of serving large areas is to establish satellite centers, or branch offices. Some of these are virtually independent; others depend in varying degrees upon the main office for advice and manpower. Many rural centers also set up outreach stations, open perhaps only a few hours a week or one day a month, to bring mental health services to the more remote sections of their catchment area. In emergencies the centers try to give immediate help. The center in northern Wyoming, mentioned earlier, has a full-time mental health professional in each of the four county seats. Says the director: "We try to allocate professional people in proportion to the population density. The basic idea is that we do not want people to have to travel more than 30 minutes to get to one of our offices. Our staff is mobile: I'm a roving psychiatrist—a circuit rider if you want to call it that. I make regular junkets around the area, stopping with the staff in each office."

The center based at Flagstaff, Arizona, which is responsible for an area larger than all of New England, with a population of close to 200,000, nearly half of it Indian, began building upon five scattered community clinics, only two of which had a full-time professional worker. (47) For inpatient facilities, it used the Flagstaff Community Hospital, other general hospitals in the area, and the Arizona State Hospital, at Phoenix. The Arizona Highway Patrol and local police departments stand ready to provide emergency transportation. For persons within 50 miles of Flagstaff, a group of clergymen and two psychiatrists have developed a program that responds 24 hours a day to telephone calls for assistance. Services for Indians have been developed in collaboration with the Public Health Service, the Indian Health Service, and tribal councils.

Serving the Community's Caregivers

Like their urban counterparts, rural mental health centers are concerned not only with treating the mentally ill and the emotionally disturbed but also with preventing mental and emotional disability of all types. The centers' preventive programs, and some of the treatment efforts as well, center on such care-giving personnel as teachers, physicians, nurses, lawyers, policemen, court personnel, and clergymen, all of whom are in a position to influence for better or worse the mental health of the persons they encounter and if given a grounding in mental health principles and practices, can recognize mental disorder early enough for the most effective treatment.

Potentially the most valuable work a center can do is to help fit the community's caregivers to provide in their daily activities the kind of care that promotes mental health. Rural centers across the country are doing this—some better than others—through educational courses and conferences and through consultation on specific problems whenever needed. A center in Vermont, for example, trained general hospital nurses to handle psychiatric patients so that these could be treated close to their homes instead of in the distant State hospital. (*51*) It also instituted a school consultation program that uncovered many cases of potentially serious emotional or mental disorder. A large, predominantly rural center in Maine placed two specially trained clergymen on its staff to consult with other clergymen, individually and in groups. The aim is to help the clergymen deal with troubled parishioners early and skillfully, and thus lessen the need for these people to call the center directly. The Range Mental Health Center in Virginia, Minnesota is not technically a rural center but situated in the midst of a large rural area. The center devotes approximately 60 percent of its staff time to consultation, training, education, information, and collaborative services. Almost every caregiver in the area is seen at least monthly by a traveling staff team or individual. (*52*)

At the very least, such programs—other examples of which appear in the following chapter—help an area's caregiving personnel to understand the behavior and the emotional needs of their clients. By helping the caregiver, wherever he is, become a source of referrals to the center and, in some cases, a treatment agent himself, the programs also serve to mitigate the transportation problem.

Special Services

With the help of special NIMH grants, many centers serving predominantly rural areas have expanded their programs to include special services for children and their families and have introduced special alcoholism programs. Some rural centers, too, are making special efforts against drug abuse and juvenile delinquency. Examples of such programs are given in Chapter V.

County, State, and Regional Differences

In the earliest years of the mental health center movement, rural counties that had a college or a university were more likely than others to have made plans for a center and had the plans approved and funded. By the middle of 1969, however, this difference had disappeared; further, no relationship was found between the presence or absence of other resources—including mental hospitals, institutions for the mentally retarded, Veterans Administration hospitals, and permanent mental health clinics—and the funding of mental health centers.

The study which led to these findings concluded that the funded rural counties were reasonably representative of all rural counties. (*53*) It noted, too, that counties with low per capita income had been brought within the service areas of mental health centers faster than the others even before requirements for matching NIMH grants with local funds were considerably eased for federally designated poverty areas. But the study found also that of the predominantly nonwhite counties—totaling approximately 150 and peopled largely by blacks, Indians, or persons of Japanese ancestry—only about 7 percent were covered.

Some States and regions have been more successful than others in achieving mental health center coverage for their rural counties. Kentucky has been unusually successful: As early as 1970 it had 21 operating centers; by mid-1972 it had 23, covering the entire State. Such progress in an area that includes some of the poorest rural counties in the Nation and that has had a minimum of psychiatric services available can be credited mainly to the imaginative leadership of the State department of mental health and to the dedicated participation of local residents. Citizen-led mental health and mental retardation boards were chartered throughout the State as autonomous, nonprofit corporations to provide mental health and mental retardation services to regions comprised of a number of counties. An advisory council of professionals and a government advisory council of county judges and local mayors assist each board. The State provided technical assistance in planning and in community organization to help get the centers started; it now provides consultation by mental health professionals to center staffs and boards and, where necessary, it offers direct services to fill gaps. Another important factor was the Federal provision that funds of the Appalachian Commission, a Federal agency, could be used in helping centers match NIMH construction and staffing grants. Centers outside of the Appalachian region receive no comparable help, for the funds of no other Federal agency may be so used. One of the Kentucky rural mental health centers is described in Chapter V.

North Dakota, too, has an unusually good record, attributable to an early start, in 1963, on its mental health center program through comprehensive mental health planning—attributable also to steady development and to the authorization of counties to vote a tax to finance mental health services.

On the basis of the proportion of rural counties served by a mental health center, the New England States also rank above average, Maine leading with 100 percent. The New England achievement may be credited not only to that region's interest in better services but also to the circumstance that it has only 33 rural counties to be covered. In contrast, some of the midwestern and far western States have poorer than average records, at least partly because they must contend more than most of the others with the problem of serving people distributed over vast areas.

Evidence of Success

The value of any health system that has been operating only a few years is hard to measure. Certainly, however, millions of rural people now for the first time have ready access to mental health services. As one example, the huge, 16-county catchment area of the center in eastern Montana—an area larger than that of many States—not long ago had no psychiatrists or psychologists in private practice, no psychiatric hospitals, no mental health clinics, no psychiatric social workers, and no psychiatric nurses. (*40*) The State hospital was as far as 600 miles away from some points in the region, and still is. But now, the center reports, emergency cases are seen within 4 hours—"regardless of geographic location"—because the center has permanent offices in two cities and a staff that is often on the road. As evidence that the region knows about and appreciates what the new agency is doing, 15 of the 16 counties levy a per capita assessment paid directly to the center.

Certainly, too, the caseloads of the rural centers attest that very many of the people needing mental health services are getting them. For instance, the Vermont center described in the next chapter recently had a caseload of 800 patients, three-fourths of them new, and the Kentucky center described in the same chapter had a caseload of 1,500, an increase of 1,100 in 5 years. Further, in center after center, programs to enhance the ability of the community's care-givers (the schools, the legal system, the churches, and other agencies and individuals), to identify troubled children and adults and treat or get treatment for them, along with programs to enlist and train volunteers and nonprofessional workers, provide strong evidence that the centers are raising the general level of mental health knowledge and thereby increasing the community's ability to prevent as well as to treat mental illness.

A commonly used gauge, though unsatisfactory by itself, concerns changes in the number of persons who enter or reenter the State hospital or who are members of its population on a given date. Centers usually report a significant decline in at least one of these measures. Six months after the center in Aroostook County, Maine, began full operations, for example, monthly admissions to the State hospital from that area had dropped more than 70 percent. In northeastern Vermont, the region's population at the State hospital dropped 68 percent in one year. In eastern Kentucky a center estimates that its programs have reduced by at least 50 percent the proportion of mentally ill persons who must enter the State hospital.

A number of centers report, too, that county officials are less ready to order persons committed. Where it was routine for a sheriff to pick up someone considered deranged, perhaps hold him in jail for a few days, and then take him to the State hospital, it has become increasingly customary to consult with the mental health center on a course of action. (*55*) Centers work closely with law officials. Many offer them consultation. At least one makes a regular check of the jails and frequently admits prisoners to its partial hospitalization program. (*56*)

After the centers have been operating for some years, it may be possible to demonstrate that they are affecting State hospital admissions and populations in another way—by reducing, through their preventive programs, the rate of occurrence of mental illness.

As a means of conveying the problems common to most rural mental health centers and the different ways taken to meet these problems, and as a means of suggesting the effect of the new programs upon the mental health problems of the areas served, the following chapter presents five centers as examples. Probably no mental health center can be called typical, but each of these five does typify in many respects the problems and achievements of rural mental health centers across the nation.

> *We are beginning to realize that mental health is the sum total of the quality of a man's environment, the quality of his life, and the way he leads it.*
>
> —*Bertram S. Brown, M.D.*

CHAPTER V

RURAL MENTAL HEALTH CENTERS: FIVE CASE HISTORIES

Chapter IV discussed the development of the community mental health center program, with special attention given to the problems and some of the accomplishments of centers in rural areas. The intention in that chapter was to give a bird's-eye view of rural centers. To round out the picture, this chapter presents five closeups.

The first section describes a center in the eastern Kentucky mountains that has successfully used many paraprofessionals to help in the delivery of mental health services, even during an extended period when the center had only a part-time psychiatrist.

The second deals with a center in Vermont that provides an unusually wide range of direct services—because its large territory stood in need of them.

The third discusses a center in Aroostook County, Maine, that is particularly proud of its indirect services to teachers, clergymen, the sheriff, and police.

The fourth looks at another Maine center that has opened six regional and eight outreach offices and counts on 400 volunteers to help it put services within reach of everyone.

Some centers have started from scratch. Others, like the first four reported here, have succeeded small clinics or counseling agencies. In contrast, the fifth section of this chapter deals with a rural center in Kansas that developed from the inpatient service of a small psychiatric hospital. This center has worked intensively and successfully to involve itself with the community.

1. Appalachia: Making Mental Health Manpower Go Around[1]

The catchment area of Mountain Mental Health Services, a community mental health center in eastern Kentucky, takes in only 160,000 people but covers five whole counties spread over a sizeable chunk of the Cumberland Mountains. Scenically, this section of Appalachia is among the country's richest; economically, one of the poorest. Most of the land runs up and down, and most of the people live in narrow valleys carved by the Big Sandy River and its tributaries or in isolated "hollows" between hills. The soft coal mines, the largest source of jobs, have for years been needing fewer and fewer men. Unemployment runs double the national average. One of the five counties ranks as the poorest in the Nation; another, as the third poorest.

It was in this area that a psychiatric nurse and a psychiatric social worker from the nearest State hospital—then 5 hours away—began working in 1964 with the hope of reducing hospital admissions and of helping the residents establish a permanent mental health facility. As related in Chapter III, both hopes were realized.

The community mental health center that developed from the demonstration project faced a pile of problems. When it was established in 1967, it had to scrounge for working space, which it eventually found in a variety of unlikely places, including a former automobile showroom in Prestonsburg; a long-vacant suite of offices—cleaned up, repaired, and painted by staff members over a period of many months—next to Gertrude's Beauty Salon on the second floor of Prestonsburg's Odd Fellows Building; the cellar of Heritage House, a former residence that is now headquarters of the Pikeville Woman's Club; and the cinderblock Weeksbury Community Clubhouse, along a creek running through a coal company town that has been abandoned by the company but not by the residents. The Center also had to overcome the suspicions of a number of M.D.'s who were slow to make referrals. The Center faced other and more important problems, such as how to serve its broad catchment area with a very thin staff. At one time it included only one psychiatrist, and he was able to give the

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[1] Condensed and revised from Yahraes, Herbert. A community mental health center in Appalachia. In: *Mental Health Program Reports—5*. DHEW Publication No. (HSM) 72-9042. Washington, D.C.: Supt. of Documents, U.S. Government Printing Office.

Center only 2 days a week. The following sections tell how the Center approached this and other major difficulties.

Services Through Area Teams

When Richard T. Stai, a social worker, accepted the position as executive director of the new agency, he thought it might be possible to concentrate his resources at one or two locations and to serve distant areas by periodic clinics. As he poked into the distant corners of the catchment area, however, he concluded that fairly autonomous area teams would have to be established, each of them a miniature mental health center trying to meet through its own resources and those of headquarters all or most of the basic elements of service required for NIMH support.

There are now three such teams. The first is in the headquarters city of Prestonsburg and the second, 35 miles south, in Pikeville. Each of these serves one county and conducts weekly or monthly clinics in outlying settlements in order to do so more effectively. The third area team is based in Paintsville, 15 miles north of headquarters; in addition to its home county it is responsible for two others, in which it maintains full-time offices.

Each area team has an outpatient clinic and offers round-the-clock emergency service—through its own office on weekdays and through the Prestonsburg General Hospital at other times. (A nurse at the hospital takes calls for the Center and gets in touch with a member of the agency's staff.) Each provides consultation to doctors, teachers, and other professional people who ask for it and offers educational services—newspaper stories, radio reports, talks to groups—generally through members of the headquarters staff. Each team also provides inpatient service. In theory, the region's four general hospitals that are affiliated with the agency have each provided several beds for mental patients, but for lack of psychiatrists and psychiatric nurses these have been infrequently used, and never for more than a few days. Most patients requiring day-and-night hospitalization have gone until recently to the nearest State hospital, in Lexington, which can be reached over new roads in 2½ hours. Since the spring of 1972, the principal inpatient facility has been a 20-bed ward—made possible by an NIMH construction grant—in a new wing of the Methodist Hospital in Pikeville. This city is the seat of the region's most populous county, from which come half of the center's patients.

All three teams also provide daycare programs, which serve about 160 patients. On a typical day, 19 of the patients enrolled in the Prestonsburg program were listed as psychotic, 13 as neurotic, 10 mentally retarded, five with personality disorders, four with organic brain syndromes, and three as alcoholics. The distribution in the Pikeville and Paintsville programs was similar.

Because of the region's transportation problems, most patients attend the daycare sessions no more than once or twice a week, though a few manage to get there more often. Attendance at each session runs to eight or 10 patients a day. About half of these are picked up and taken home by driver-aides.

The Use of Paraprofessionals

The area teams are headed by either a social worker, a psychiatrist, or a psychologist. Each team includes one or two other social workers or psychologists and a number of persons classified as "mental health workers," meaning people who provide some of the mental health services usually provided by mental health professionals but who do not have a professional degree. Of the approximately 105 persons on the Center's staff, about 35 are professionals and about 40 are mental health workers. Almost all of the latter grew up in this section of Appalachia and have had experience either in social service agencies or as teachers. One is a major in political science who decided he wanted to work with people. One majored in psychology and was serving in Vietnam as an Army social worker when the Center opened. One woman on the Prestonsburg team has a master's degree in English; another was a nun. Two women on the Pikeville team used to be with the Public Assistance office; they have worked for the Center almost since its start and are considered among the most valuable members of its staff. The minimum educational requirement for mental health workers is 2 years of college. Persons with a degree started at $6,000 in 1972; the others, $5,000.

Mental health workers are used both as intake interviewers and as supportive therapists. In the latter roles they are assigned to patients judged likely to benefit from having someone who can spend considerable time listening to them and helping them meet —with the aid of medical, welfare, and other community services —their most pressing problems. They are generally assigned to the older, more chronic patients but, in Stai's words, are used "in the whole gamut of mental health center tasks except diagnostic testing, writing prescriptions, and helping patients develop insight—and several of the more experienced ones do that, too."

Stai believes that with certain kinds of patients, the center's mental health workers can be at least as successful as more highly trained people from outside the region. "Anybody who is really interested in helping," he says, "can be trained to be as helpful with a limited population as a psychiatrist or a psychologist." The workers frequently consult with their team's director and receive continuing training in weekly meetings of the staff and in monthly, all-day "regional staffings" in the headquarters city.

Why the Mobile Team Approach Failed

After consulting with NIMH and State officials shortly after the center opened, Stai decided to bolster the mental health resources of each area through what he called a *psychiatric mobile team.* The mobile team's membership comprised the psychiatrist, a supervising social worker, a psychologist, and a medical records librarian serving also as a secretary.

This plan never really worked. For one thing, because members of the team did not live close to one another (*could* not, in a region of small towns, great distances, and housing shortages), members could rarely travel as a unit. For another, Stai was concerned because the area teams, waiting for the arrival of visiting professionals, postponed day-to-day decisions and thus remained largely dependent.

All attempts to visit local offices as a team or even in smaller groups have been dropped. And the scheduling of visits by central office staff to local offices is no longer done by the medical director, or by anyone else at headquarters. It is done by local teams. "We still have the same staffing pattern," Stai comments, "but we call these people—professionals in the central office—mental health specialists and send them on their way as individuals."

Making Do With a Part-Time Psychiatrist

Both the executive director and his two principal assistants are social workers. As medical director during its first 3 years the agency had a succession of full-time psychiatrists. The first left to take a better paying position with another mental health center; the second, Dr. James Bland, to become deputy commissioner of medical services in the Kentucky State Department of Mental Health; the third, to work in a hospital setting, which he preferred. Dr. Bland then came back on loan from the State, and for almost two years worked for the center 2 days a week as its only psychiatrist.

"It probably would have been easier to recruit a psychiatrist if he had been offered the position of executive director," Stai says. "But the more we thought about it—we being the board of directors—the more we thought we could get that job done cheaper and just as effectively with someone other than an M.D. as the director. For instance, my time is almost entirely tied up with administrative functions—recruitment, personnel, the business end of it, grantsmanship. And it sure costs a lot less to pay me to do that than it would an M.D."

In other words, Mountain Mental Health Services set out to make what it considered the wisest use of a scarce resource. Its clinical staff—among whom it counts its mental health workers as well as its psychologists, nurses, and social workers—serve as the psychiatrist's eyes and ears. Members brief him on the new patients and introduce him to many of them. He prescribes the treatment, advises the therapist, and is available for telephone consultation almost any time. When Dr. Bland was the only psychiatrist and could serve the region only part-time, he spent 1 day a week in Pikeville and got to the other counties several times a month.

As of spring, 1972, the Center had two full-time psychiatrists in addition to Dr. Bland. One was giving most of his time to the new inpatient facility; the other was developing a children's program.

In sum, this center has used psychiatrists primarily as consultants to its other therapists. From the beginning it has had five general practitioners or internists on its staff as medical consultants, one in each county. They are available to write refill prescriptions, to order changes in medication—often at the suggestion of some other member of the staff—when a psychiatrist isn't available, and to help handle emergencies. The center would be hard put to function without them.

Services for Children

For several years the Center did, in Stai's words, "a lousy job with children." An NIMH review team once told him that in many mental health centers across the country about 45 percent of the patients were children and young people. But in Mountain Mental Health Services the comparable figure was around 5 percent. The Center attributes this poor showing in part to resistance by teachers and parents, a resistance arising from the notion, still common in the region, that a person who goes to a mental health clinic must be either crazy or poor. The Center thinks, too, that it might have done a more effective job of following up its first contacts with the schools. In any event, in recent years the Center has made services for children its first priority.

Between 1970 and 1972, the Center:

- Added to its staff a child psychiatrist to develop and help provide services for children in all five counties; a psychologist (Ph.D.) to evaluate children and consult with school personnel; a guidance counselor—a specialist in the education of disturbed children—who works with a number of children on an individual basis and tries to help others by working through their teachers; and master's degree people on each area team who work primarily with children and their families.

- Opened a Children's Unit that provides a day-treatment program for a dozen disturbed children and three training programs for more than 30 mentally retarded children. In each program the children range in age from 5 to 18 years. Because of the transportation problem, the Children's Unit—located on an estate in Pikeville that the agency has bought—serves only about half of the catchment area; one or two other units may be opened eventually in other parts of the region.
- Entered into contracts under which the Center provides diagnostic evaluation, treatment, consultation, and classroom mental health education to five school districts.

Because of these and other activities made possible by the expansion of staff, the Center estimates that children and young people now constitute close to 20 percent of its case load, or almost four times the earlier share.

Helping Mentally Retarded Persons—and the Elderly

In addition to developing the Children's Unit noted above, the Center has opened a mental retardation center in Pikeville where a dozen adults classified as either moderately or severely retarded are being trained in needed skills. These range from how to tie shoes and comb hair—if that is what the retarded person needs training in—to how to get along with people under various circumstances and how to follow directions. Some students are trained for simple jobs in the community. Others will be graduated into Pikeville's new sheltered workshop.

This work has been made possible by grants from the Model Cities program in Pikeville, to pay the rent, and from the Division of Social and Rehabilitation Service, DHEW, to pay staff salaries and buy vocational rehabilitation equipment.

For the mental retardation programs the Center has employed half a dozen elderly persons as members of the staff. It expects to demonstrate that some persons on the far side of 60 make excellent assistants in such programs. The salaries of these older staff members are being paid by a Social and Rehabilitation Service grant.

The Center also provides consultation and testing services to daily programs for retarded children operated by two county mental retardation associations.

Alcoholism Program

Almost from the beginning the Center had a part-time alcoholism program coordinator charged with establishing Alcoholics Anonymous and related groups, counseling alcoholics, and directing an educational program on alcoholism. Under an NIMH grant this position has become full-time, and the agency has hired five alcoholism counselors—one for each county—to assist him. They work with alcoholics both individually and in groups. The center says alcoholism is a serious problem in this legally dry region but probably no more so than many other sections.

The Eastern Kentucky Syndrome

Mountain Mental Health Services encounters many cases of "Eastern Kentucky Syndrome," a condition characterized by moderate depression, aches and pains, rapid heartbeats, and spells in which the patient feels he is being smothered. It is the agency's most frustrating clinical problem. Typically the afflicted person is a man between 25 and 50 years old who has been injured in the mines and cannot qualify for workmen's compensation, or Social Security payments, or a miner's pension, or welfare because little or no physical disability remains. But he has "bad nerves" and keeps going to doctors. Finally, he is referred to the center to determine if he is sufficiently disabled mentally or emotionally to qualify for some type of pension. The psychiatrist prescribes medicine to relieve anxiety or depression, or both, and the man comes to one of the outpatient clinics several times a month and in some cases attends a daycare center.

"What happens usually," says T. M. Atkinson, the center's clinical coordinator, "is that in the beginning they turn into a compensation neurosis—they are going to be rewarded for being sick if they are sick enough, so they are trying harder to be sick, unconsciously or subconsciously. They need to be sick in order to get the money from Public Assistance, or whatever. We feel that they are afraid to go back in the mines. They may be afraid to go back to work in general. Maybe they are afraid of a lot of things.

"What we want to do is to direct their attention away from their fear of going back to the mines; then send them to vocational rehabilitation for training in some other occupation. We are not very successful, very often, as far as getting them back to work is concerned."

Stai, the executive director, adds that some sort of guaranteed minimum annual income may be the answer. "We think there has to be a change in the system," he says, "because the system as it is now in Eastern Kentucky does make people sick. One of the surest ways of making a living here is to get sick or disabled because there are so few job opportunities, and these are mostly in mining —a very hazardous occupation both physically and psychologically."

"One of the ironic situations," says Atkinson, "is that there are so many things that need to be done in the area of social service, medical service, the educational system, and there are so many bodies needing work, yet they are not trained to meet the needs. We have lots of unemployment, and we have lots of work that needs to be done, and we haven't gotten the two together. This is one of the things that we do in a small way in the daycare centers. These people need services that can't be provided by building another building or building a road; they need help that can only come from other people."

People Served and Money Raised

During its fourth year, ending in mid-1971, the Center gave some form of service to more than 3,600 people. The following spring it had an active caseload of about 1,500, as compared to the 400, inherited from the demonstration project, with which it had started life. Of the 1972 case load, about 1,300 were outpatients, 160 were in daycare, and 45 were inpatients, a third of them in the new inpatient facility and the others at Eastern State Hospital.

Stai estimates that the agency's programs have reduced by more than half—probably by almost three-fourths—the proportion of mentally ill persons in the five rural counties who must go to the State hospital. He suspects that the *number* of persons going to that hospital may have somewhat increased because the Center's activities have led to greatly improved case-finding. The average length of stay in the hospital has been greatly reduced, presumably both because of improved hospital programs and because of the Center's aftercare services.

The Center's budget grew from about $175,000 in 1967–68, its first full year, to $1,400,000 in 1971–72. About $880,000 of this last budget came from NIMH staffing grants, including special grants for the alcoholism, mental retardation, and children's programs; about $80,000 from Kentucky's Department of Mental Health; and about $440,000 from fees for services.

Income from services included approximately $200,000 from Medicaid (which pays at the rate of $16.80 per visit); $85,000 from a contract with the United Mine Workers Rehabilitation and Retirement Fund; $155,000 from other patient services such as those performed under contracts with school systems and other agencies.

The budgetary increases through the years have been accounted for almost entirely by increases in the professional staff, with accompanying increases in the services offered and paid for. Stai expects to compensate for the eventual loss of Federal support by a rise in local support. He points out that under a recent Kentucky law, counties are permitted to support mental health services by imposing a real estate tax of up to 4 cents per $100 valuation. Such a tax throughout the Center's catchment area would raise about $250,000, which, with increased income from services and with support from the State, would enable the Center to meet its needs.

The people of the five mountain counties would not approve a mental health tax tomorrow, Stai is sure, nor perhaps next year, but he doesn't consider the situation hopeless. "We have several years—before Federal support ends—to demonstrate to the communities that we offer a needed and reliable service," he says. "Direct services are absolutely necessary in Eastern Kentucky to demonstrate the values of a mental health center. With every month we are offering more services to more people. And we are gaining expertise in the effective delivery of nondirect services."

2. Northeast Kingdom: A Rich Variety of Services[1]

In northeastern Vermont, near the Canadian border, a community mental health center with an unusual name is offering an unusual variety of services. And it has made an unusual record.

The center is the Northeast Kingdom Mental Health Service, Inc. It serves three counties that are set off from the rest of the State by mountains and rivers and was once described by Sen. George D. Aiken as his "northeast kingdom." The name has been widely adopted. From the standpoint of natural beauty, this remote rural region, with its numerous lakes, rivers, and mountains, is indeed a kingdom. But economically it is a kingdom in need. Agriculture, on which it still mainly depends, has declined, and though some industry has come in, jobs are scarce and the unemployment rate higher than the national average. Half the center's patients fall below the official poverty level, and most of the rest, like most other Kingdom people, the staff reports, are poor.

The catchment area, roughly 65 miles from north to south and 35 from east to west, covers 2,500 square miles. About 50,000 people, many of French-Canadian descent, are scattered over it in 60 towns and villages. The temperature sometimes falls to 40 below in the winter, and the highways, particularly the secondary roads, are sometimes blocked by snow. Taxis are the only public transportation.

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[1] More detailed accounts of this center and of the two Maine centers included in this chapter appear in the forthcoming *MENTAL HEALTH PROGRAM REPORTS—6.*

The Center's headquarters is an old red brick mansion in Newport, a town of 5,000 people a few miles south of the boundary between Vermont and the province of Quebec. The Center has an office, too, at St. Johnsbury, a town of 8,000 about 45 miles south of Newport. Under an interesting arrangement between States, it also has facilities on the other side of the Vermont-New Hampshire line, at Colebrook, 50 miles by automobile east of the Center's headquarters. This New Hampshire town is the shopping and business center for many of the 6,000 residents of the Northeast Kingdom county of Essex, where the people are said to be outnumbered by the black bears.

Thanks to the Center, the majority of the people in the catchment area are now within 20 miles of mental health services.

Summary of Programs

Because the Northeast Kingdom lacked many of the health services commonly found in urban areas, the Center tried to provide them. In addition to the usual services of a comprehensive mental health center, this agency offers:

- A foster home for unmanageable adolescents and other troubled children. The home provides a therapeutic setting in which these youngsters can work out their problems instead of being sent to a training school or forced back into an unhealthy situation with their families. Equally or even more important, it serves as an emergency shelter and a diagnostic screening and evaluation center for children who have been picked up by the police or who for other reasons have come to the attention of the District court or the regional Division of Child Welfare. During the first 13 months of the new program, the home sheltered 24 boys and girls, a maximum of nine at one time. They ranged in age from 12 to 17 years. More than half came in for emergency shelter and usually stayed only a night or two. The others were long-term placements.
- Consultative services for teachers and counseling services for problem children and their parents. The services are provided under a contract between the center and a group of 14 school districts acting together to get services that an individual district cannot provide. Two staff members spend almost all their time in the schools and the homes. The elementary grades are the principal target because their teachers are without the help of either guidance personnel or building principals. During the program's first year the schools referred 160 children to the center's school team. Among them were undiagnosed hyperkinetic children, children with learning disorders of various types, and troubled adolescents, including four pregnant girls.
- The services of a speech therapist, who originally worked

mainly at the center's headquarters but became a member of the traveling school team in 1971.

- A summer activities program for children from six to 12 who have been named by the teachers as problem children.

- A combination of sheltered workshops and special classes directed especially toward the needs of people who are mentally retarded or educationally and economically disadvantaged. The program is the only one in the catchment area that provides academic instruction and training in work skills and in social adjustment for mentally retarded persons too old for public school. Consequently, most of its clients attend under arrangements made with the center by the Neighborhood Youth Corps, by Operation Mainstream, which is an Office of Economic Opportunity program for young people, or by one of two divisions of the State government—vocational rehabilitation and special education. At any one time the program serves 35 or 40 such clients. The workshops also serve as daycare centers for a few persons who are either outpatients of the center or former State hospital patients.

- Services for the staff and inmates of the State's regional correction center in the Northeast Kingdom. These services, provided under contract with the State Department of Corrections, include group therapy and staff training.

- A drug rehabilitation program, financed by a grant from the Office of Economic Opportunity, which includes open house for young people six evenings a week at the agency's headquarters, known to youngsters throughout Newport and the surrounding countryside as "The Rooms." The prevalence of drug abuse in this area is unknown but believed to be very high. Lack of jobs for young people is considered to be one major cause. In addition to the director and a street—or outreach—worker, the drug program includes a number of volunteers. Among these are teachers, businessmen, farmers, clergymen, guidance counselors, State policemen, and former drug abusers who give talks at The Rooms and provide counseling. When there is no scheduled speaker, the youngsters drop in to socialize, read magazines, or become part of an informal discussion group. Up to 20 or 25 a night attend. The drug program includes crisis intervention, with the help of the center's mental health professionals and of local physicians; job counseling; and drug education. A similar program is underway at St. Johnsbury.

- Services in the interest of physical as well as mental health. The mental health agency combined its resources in 1970 with those of Public Health Nursing, a State program, to bring Home Health Services to the region. These services include professional nursing care, physical therapy, and mental health counseling, all delivered to the sick and disabled at home when requested by a physician. Though similar programs, which are financed largely by Medicare and Medicaid, have sprung up across the country, few are sponsored by mental health centers. The Northeast Kingdom center points out that the region needed such a program and that the

> Center was the logical agency to sponsor it because mental health is inseparable from physical health and also because the Center already had some of the personnel required for such a program.

Eventually the center hopes to concern itself with the health of the entire family, at every age. It already sponsors a monthly Well Child Clinic, with facilities and part of the staff provided by the center and pediatricians by the State's Child Health Services. The Center also sponsors classes for expectant parents and for new parents. "We feel very strongly," says an official, "about providing services wherever there is a lack—services that the people need, whether or not they are primarily mental health services." In accordance with this philosophy, the agency opened both a senior citizen and a youth center in St. Johnsbury, where there had been neither, and initiated area-wide comprehensive health planning. All three programs are now under independent management, by citizen boards or committees.

History and Staff

The Northeast Kingdom center opened in June, 1967. It succeeded a small family counseling agency that had begun operation in 1963 under the direction of a young clinical psychologist from the Midwest named Gerald D. Errion. In fact, he was the sole member of its professional staff.

Errion eased the usually difficult task of recruiting professional mental health personnel for a rural area by filling three key posts with former associates of his at the Mental Health Institute. This is a State mental hospital, at Clarinda, Iowa. One of the group from Iowa is James P. Erwin, a psychologist who now functions both as a therapist and as the center's associate director. Another is George Coulter, Jr., who has a master's degree in recreational therapy and is coordinator of the center's rehabilitation services, which include workshops and special classes. The third is Fernando A. Duran, the psychiatric nurse who developed the Clarinda plan for grouping mental hospital patients by geographic units, each with its own treatment team. Duran is the Center's coordinator of continued care, a position that he and Errion have interpreted as taking in, among other activities, (1) offering training in the care of psychiatric patients to the nurses in the area's three general hospitals; (2) persuading the State hospital to introduce the unit system so that many of the patients from the same area can live in the same hospital unit and be cared for by the same doctors and nurses, an arrangement intended to increase both the responsibility and the motivation of the treatment team; (3) interviewing most of the Northeast Kingdom patients before they enter the State hospital, and following them upon their return; and (4) spending the rest of the time in individual therapy and in consultation.

For several years the Center's staff included a full-time psychiatrist. When he left in 1970, the Center fell back on its psychiatric consultant—Dr. Hans Huessy, of the University of Vermont's school of medicine, 70 miles away in Burlington—until it could find a replacement. Every other week Dr. Huessy has been spending half a day in Newport and half a day in St. Johnsbury, seeing patients and consulting with staff members. In 1971 he was joined by two associates, keeping a similar schedule. Emergencies—for example, a new patient who needs medicine at once or an old patient who seems to need a change in medicine—are handled by telephone.

The other members of the staff are New Englanders, in the main, though only one is a native of Vermont. They include another psychologist, three social workers, two group foster home parents, the speech therapist, a coordinator of community resources, a drug program coordinator, and eight "adjunctive therapists," most of whom are the foremen, teachers, and activity directors in the agency's shops and schools.

Caring for Patients

The Center boasts that it has no waiting list. Anyone applying for help receives an appointment within a week or, if the problem is urgent, the same day. At Newport a new patient is generally assigned to the mental health professional who at the moment has the most open time. This therapist sees the patient once and brings the case before the Clinical Review Committee, headed by Duran, the following Monday morning. On the basis of the diagnosis, the patient's apparent needs, and the particular skills and interests of the staff members, the committee decides who shall be in charge. A similar system operates in the St. Johnsbury office, staffed by a psychologist, two social workers, and, 1 day a week, the psychiatric nurse and the associate director.

In 1971 the Center had a caseload of about 800 patients, of whom 600 were new. These totals include only those individuals for whom contact with the center led to a series of meetings with one or more staff members. Not included are those children and parents—the majority—who were served in the school program but who did not go to the Center. Most of the referrals to the Center that year were made by the patient's family, school, or private physician. Reflecting the good relations between the Center and other community help-givers, the rest of the patients were referred by some 20 different agencies and by clergymen and lawyers.

Whenever possible, patients requiring hospitalization are sent to one of the general hospitals in the area, which have agreed to make 10 percent of their beds available for psychiatric admissions. These average about eight a month. Admissions are arranged by local doctors, and treatment is generally conducted by them in consultation with the Center.

Of particular pride to the Center's staff is its achievement in keeping Northeast Kingdom people out of the State hospital, which is at Waterbury, 65 miles from Newport. In Vermont, as in the country as a whole, the number of people in the State hospital at any one time—its *population*—has been going down, though the number of *admissions* has been going up. The Northeast Kingdom, however, shows a decline not only in the number of its residents among the population of the State hospital but also in the number of people admitted to that hospital. During a recent 2-year period, the region's total admissions, as compared to the preceding year, decreased 5 percent.

A year after a version of the Clarinda plan was introduced at the Vermont State Hospital, total monthly admissions from the Northeast Kingdom were averaging five; discharges, about eight.

Social Groups

The Center's rehabilitation program includes weekly social evenings for former State hospital patients. At both Newport and St. Johnsbury, up to a dozen patients come to the Center one evening a week just to be sociable. They are persons the agency is trying to reintroduce to the community. The members of the Newport group, most of whom live and work on farms, prefer to spend the evening in talk and card playing. Those at St. Johnsbury, perhaps because most of them work in town, are more outward going; they play cards, but in summer they also have cookouts at members' homes and go out to play miniature golf.

"Sooner or later," reports the director of rehabilitation services, "the people of both groups get used to socializing, and most of them graduate." In the Newport group, however, there is a former State hospital patient who has been coming regularly for 4 years, along with three of his brothers and a sister. They live on a farm half an hour's drive from the center, and the group is their only social affair. It is also the only thing, the relatives say, that has kept the former patient out of the hospital.

Volunteers and Citizen Participants

Inspired by NIMH's Citizen Participation Branch, the Northeast Kingdom center has enlisted almost 100 women as citizen participants in mental health. The recruiting was done by letter and telephone and by visits to women in several dozen communities by the center's coordinator of community resources (meaning volunteers), Mrs. Doris Lewis. Mrs. Lewis, a native of the region, has been a member of the board of directors from the time the center was only a family counseling agency, and she served as the director's righthand man in that agency. Starting in 1970, she organized a number of seminars for her recruits. The meetings were generally morning coffee affairs at which members of the Center's staff discussed their work. The object was to acquaint the women with the Center's program so that they would become—both as individuals and as members of a club or other community organization—sources of information in their community.

The Center thinks this goal has been reached. Perhaps as important, the Center can now put its hands on citizen participation committees throughout the three counties to help it meet specific needs. Through these committees, for example, it has found a speaker on mental health for a Girl Scout meeting on a day no member of the staff could attend, directors for the older people's group that meets at the St. Johnsbury center, a tutor for a troubled youngster who needed help with academic subjects as well as counseling, drivers for patients without means of transportation, and somebody to read all the local newspapers and clip items on subjects related to mental health. A group of women from one area holds an annual picnic for the patients and staff of the Northeast Kingdom unit at the State hospital. Another group, mainly from families that spend the summer in northeastern Vermont, organized a tour of homes that earned $500 for the center.

In another part of the program, volunteers used to run a thrift shop on Newport's Main Street dealing in clothes that people wanted to sell. Half of the sales price went to the seller and half to the center. This activity, which never showed much of a profit, began to lose money in 1971—perhaps because several low-price clothing stores had come to town—and was dropped. The store now handles arts and crafts products from the Center's workshops and also from individual craftsmen of the region needing an outlet for their goods.

The Money End

The budget of the Northeast Kingdom Mental Health Service for fiscal year 1971 amounted to $403,000. Of this, $160,000 came from State and $94,000 from Federal grants. Included in the latter were an NIMH staffing grant of $43,257 and grants from the Office of Juvenile Delinquency for the foster home program and from OEO for the drug program. Income from fees was $80,000, of which almost half was paid by Medicare and Medicaid.

The Center received $69,000 for consultation services, including $13,000 from the State Department of Corrections and $6,000 for the agency's drug program.

For the Future

The Center's chief immediate goals can be summed up as *more services to children*. Some of these will come about through a more extensive program in mental retardation. Under a 1970 contract with the Brandon State School for the Retarded, the Center evaluated candidates for admission to the school from the Northeast Kingdom and recommended whether a child should be admitted or be served by an alternative program. For lack of funds, the contract was not immediately renewed, but the Center continued to evaluate candidates for admission to the school. It intends to expand existing alternatives such as special classes, foster care, and sheltered workshops, and introduce new ones so that fewer children will have to go to the State school.

Also in one or another stage of planning:

- A greater capacity for the Well Child clinic through more frequent sessions.
- A service for uncovering learning disabilities in preschool children.
- Help for the schools in providing the individualized attention required by children with learning disabilities.
- One or two additional homes for unmanageable children.
- Cooperation with the Vermont Department of Education in other ways to further its program for emotionally handicapped children.

3. Aroostook County: Strengthening the Community's Care-Givers

One of America's most celebrated and distinctive counties—Aroostook, in Maine—juts into and is bordered by Canada, to east, west, and north. It is almost as large as Massachusetts and larger than Delaware and Rhode Island combined. Ninety percent of the area is wilderness, lake-dotted and river-traversed; the rest, a long rolling strip near the eastern border, produces potatoes at the rate of a packed carload every 10 minutes from May to October. A visitor from the south enters the county—known elsewhere in Maine as "the other side of the woods"—by driving through a broad and rather grim band of swampland and spruce.

The potato farmers have had a succession of bad years, and many have been forced off the land. The county ranks first in the State as a poverty area. About 30 percent of its 26,000 families in

1968 had incomes below the poverty level. Unemployment is higher than the average for either Maine or the Nation.

About two-thirds of the county's 92,000 people live in rural areas; the others in small towns. Measured from Fort Fairfield, a community of 4,300 in the heart of the potato country, the nearest city of any size is Bangor, 180 miles away.

There in Fort Fairfield, the Aroostook Mental Health Center—which opened in October 1970—is pushing toward its twin goals: to bring mental health services within an hour's driving time of everyone in its catchment area, which is the county itself, and to bring knowledge of mental health principles and practices to the care-givers of the scattered communities—teachers, doctors, policemen, clergymen, and the like. There is no other mental health resource in this vast area except the psychiatrist at Loring Air Force Base, Limestone, and he is so busy at the base that some of the families there are referred to the Center.

Half a year after the Center opened, it had almost reached its first goal, at least in outpatient services. By establishing two full-time branch offices and two part-time outreach stations, it had placed mental health professionals no more than an hour's trip from perhaps 95 percent of the people.

Well before the first year was up, the Center had also made substantial progress toward its second goal. Notably, it had entered into contracts with 12 school districts, about half the county's total, to place a mental health specialist in their schools 1 day a week, and it was preparing to sign agreements with several other districts. Under a typical agreement, the mental health consultant has these main jobs: (1) to talk with individual teachers about children with behavioral problems or learning difficulties; (2) to evaluate such children so he can give the teacher specific suggestions for helping each one; and (3) to conduct a course for teachers in mental health principles.

If a child has a clear psychological problem requiring individual or group therapy, the consultant suggests that the family be referred to the Center. But the great run of behavioral problems in the classroom, the Center believes, can be handled most economically and effectively by the teacher—given proper guidance—because the teacher is in touch with the children 5 days a week. Says Robert R. Vickers, the executive director: "We don't go into a system and say, 'We'll take over the responsibility for something that you ought to be doing.' We go in and say: 'You've got a responsibility for educating children. Some of these children are very difficult to educate. We've got some skills that will maybe help you do your job.' "

Emphasis on Indirect Services

Six months after the Center became fully operational, with the start of its inpatient service in January, 1971, admissions to the State hospital from the vast Aroostook region had dropped from an average of 14 a month to an average of 4, or more than 70 percent. Though proud of this achievement, the Center is even prouder of other advances, described as "indirect services to the community," the results of which cannot yet be measured.

A mental health center certainly must provide direct services, says the executive director, but the indirect services will be far more important in the end because they will reach more people and because they are concerned not only with treatment but also prevention. Without an emphasis on indirect services, mental health problems will keep growing.

In addition to the school-consultant program, which is especially important because only one district in the entire county has a school psychologist, the indirect services have included:

- A number of workshops for teachers, including two that lasted 5 days. One of these, on behavior modification, was for all the teachers of one district; the other, on learning difficulties, for all the teachers of another.
- Workshops for several police forces and for the sheriff's department. As one result, several police officers have been asking the Center's advice about disturbed and disturbing persons, instead of locking them up and more or less forgetting about them. As another result, the sheriff is working with the Center on plans to place vocational rehabilitation workers in the county jail—to make the jail not just a jail but also a rehabilitation center. The VR workers would be State, not Center, employees. But the Center believes that it has a duty to help the State make the best use of its VR resources, just as it has a duty to help the sheriff carry out one of the supposed functions of imprisonment—rehabilitation. The Center also helps to screen applicants for the police force of one town.
- A consultation service for clergymen of all faiths.
- Discussions looking toward the establishment of a major in the behavioral sciences at the Aroostook State College of the University of Maine, in Presque Isle. The Center believes that the region's mental health problems, and its economic problems as well, are most likely to be solved if the young people in its colleges can be led to focus their interests on the Aroostook region instead of elsewhere.

Facilities and Staff

The Aroostook Mental Health Center has its headquarters in a main wing of Fort Fairfield's Community General Hospital, an attractive two-story, red brick building near the heart of town.

Downstairs are the administrative and outpatient offices and the quarters of the day treatment center; upstairs, a 10-bed facility for inpatients. Patients and staff can look out on lawns, a quiet street, and vegetable gardens.

The Center succeeded a three-man mental health clinic, whose services had to be confined mainly to people nearby, that had been operating for several years with State funds. That clinic, too, was located in Fort Fairfield, because this town lies in the central and most heavily populated of the county's three principal areas of population. About 55 miles northwest of Fort Fairfield, the Center has a branch office at Fort Kent, which lies across the Saint John River from Canada and is the northern end of famed U.S. Route 1. Fort Kent has outreach stations, open 1 day a week, at Madawaska, 20 miles northeast, and Van Buren, 45 miles southeast. Serving the county's southern area of population is a branch office at Houlton, about 45 miles south of Fort Fairfield.

The Center's rapid expansion surprised some of the civic leaders on the board of Aroostook Mental Health Services, Inc., the organization responsible for both the original and the new mental health agencies. Knowing that the county had lost population between 1960 and 1970 and had been officially recognized as the State's most economically depressed area, these business and professional men had foreseen difficulty in recruiting a staff. But within 3 months of his arrival, Vickers, the young social work administrator they had hired as director, had signed on 15 professional and subprofessional workers. This was about half of the total required. Six months later the Center had only one unfilled spot in its original table of organization—for a second full-time psychiatrist, whom Vickers had put off trying to recruit until he could be used most advantageously.

Vickers and his program director, Terrence Curley, also a social worker, see two principal reasons for their comparative ease in assembling a professional trained staff: first, the opportunity offered by the Center to help develop a new kind of mental health program; second, the opportunity to live "in beautiful Maine." The second, playing upon the vast interest in ecology and the widespread distaste for life in the big cities, is considered to be at least as important as the first. Both have been emphasized in advertisements in professional journals and the Sunday New York Times. Answering an ad for a psychiatrist, one New York City man wrote that he wasn't a psychiatrist—he was a sculptor—but maybe there was some way the Center could use him. He hoped so. It turned out that the sculptor had a master of arts degree, experience with Head Start, and empathy. He was hired to direct activities in the day treatment program.

Other members of the professional staff include a psychiatrist, two Ph.D. clinical psychologists, three M.A. psychologists, seven social workers with master's degrees, a psychiatric nurse, and a speech therapist. Like the director, a native of Ohio who was working in California when he received the call from Maine, all the other members of the professional staff except one were born outside the State.

The Center's staff also includes several persons described as "patient counselors," who are therapists working under the supervision of a Ph.D. psychologist. They were chosen primarily for their warmth of personality and their ability to relate to other people and were given training on the job. All of these have master's degrees and most are from Maine. Vickers reports that one woman with a degree in library science has made an excellent therapist.

The Center's expenditures during the first year, when it was building up its staff, were approximately $500,000. For the second year, with all staff members serving the full period and with several new members, they were estimated at about $610,000. About 55 percent of the second-year budget, the Center estimated, would be met by the NIMH staffing grant; 23 percent by the State and County appropriations; 14 percent by fees, including Medicare and Medicaid payments; and 4 percent each by school contracts and by hospital payment for services of the psychiatric aides on the Center's staff, as explained below.

Outpatients and Inpatients

Something more than half of the patients of this rural mental health center come in or call up of their own account. Most of the rest are referred by family doctors, with whom the Center reports very good relations. The patient referred by a doctor must make his own appointment. When he does so, the Center has found, he is virtually certain to keep it, whereas if the doctor makes the appointment, the chance that the patient will show is only 50–50.

By July of its first year, the Center had a direct-service caseload of about 400 and was serving about 120 new patients a month. Most of the latter were outpatients or day-treatment patients (meaning daycare or day hospitalization). About 15 new patients a month and 30 old ones were inpatients, cared for in the hospital at Fort Fairfield.

Instead of hiring a nursing staff to man its inpatient unit, the Center hired a psychiatric nurse to consult with the hospital's regular nursing staff. This was in keeping with its philosophy that a mental health center serves most efficiently by sharing its special knowledge with the other care-givers in the community. The regular hospital staff works the Center's inpatient unit as well as the other parts of the hospital. The Center did hire five aides to work specifically with patients in its unit, and gave them psychiatric training. As things have developed, the aides serve the entire hospital, and the hospital reimburses the Center for their services.

In a sample month, during the first year, inpatients stayed from 1 to 14 days, the average being 5.6. The unit's shorter-stay patients, typically, are (1) alcoholics, constituting about 20 percent of the inpatients, who are admitted to make sure they aren't going to develop delirium tremens, and (2) depressed persons, talking of suicide, without relatives who can sit with them. Frequently such patients leave the hospital in a day or two but come back for day hospitalization or as outpatients.

Patients are rarely treated on the inpatient unit more than 15 days. If longer hospitalization is needed they go to an institution outside the region, generally the State hospital at Bangor. Contributing to the decline, noted earlier, in the number of patients going to Bangor, is an agreement that all State hospital admissions from the county must be made through the Center.

It is Center policy both to keep its patients out of the State hospital whenever possible and to limit their stay in the Fort Fairfield hospital. "We want to deemphasize hospitalization," the executive director explained, "because one of the things we know is that it isn't good for you. The effect of hospitalization can be as harmful to a person as the problem that sent him to the hospital in the first place."

Five days a week, the inpatients walk downstairs and participate in the day treatment program, which includes a variety of arts and crafts, group therapy, and individual therapy if needed. This is one of the advantages of having all the Center's facilities in the hospital: the inpatients can readily share the activities program developed for the day-care patients. Vickers sees other advantages: (1) people are used to coming to the hospital and (2) doctors and center staff members bump into one another at the hospital and thus, probably, develop a closer relationship.

The director also sees a grave disadvantage: locating mental health facilities in a hospital tends to strengthen the idea that mental illness, like physical illness, is a state from which a person can recover simply by having somebody do something to him, rather than a state in which he may be given medication but only so he can do something for himself.

Under plans being worked out as the agency began its second year, the Center will retain some of the advantages of both systems—being located in a hospital and not being located in a hospital. Its administrators planned to move its outpatient offices to the first floor of a two-story medical office building to be erected by and just back of the hospital. They thought they might also move its day-treatment program to a house in the community or on a small farm nearby.

The Center's other locations probably will not be changed. The branch offices at Fort Kent and at Houlton are also in general hospitals, because the hospitals' administrators, who were on the Center's board of directors, offered space. The outreach station at Van Buren is in the parish house of a Catholic church; the one at Madawaska, in a Civil Defense headquarters.

In spite of its branch offices and outreach stations, the Center has a transportation problem. Families without a car have to depend mainly on neighbors and taxicabs, for the only bus service in the county is a trip from north to south and another from south to north once a day.

To remove some of the stress from patients who don't have transportation, the Center hopes to have VISTA provide a few drivers and to recruit others from among housewives. The Center is also considering invitations to open branch offices at both Caribou and Presque Isle, two of the county's main population centers. Although these towns are relatively close to Fort Fairfield, the proposed new branches would save many patients a round trip of 20 or 25 miles.

Seeking Answers to Deep-Seated Problems

The most common type of mental illness encountered by the Center is depression, including the many cases manifested by alcoholism.

Once in awhile the depression is attributable to cabin fever, a complex of symptoms sometimes found among long-isolated people in the northland. The symptoms may range from hallucinations on down to intense irritability. However, the staff attributes mental depression more to the region's economic depression than to its long winters. "People without money are more likely than other people to find life unendurable," Vickers remarks, "particularly if they are also without avenues of self-expression."

In the Center's view, lasting answers must be found both by improving the economy of the area and by helping children and young people find ways of expressing themselves. That is one of the reasons the Center gives its work in the schools a high priority. "If we can help the kids in the schools to have a better balance in their lives," says Curley, the program director, "it seems logical that at a later point they will handle things better."

"Many of them have been doing that," Vickers comments, "and what they have been doing is leaving." He points out that this county of less than 100,000 people has four colleges and a vocational school for high school graduates. "So a lot of people are being educated, but then a lot of them can't find work."

As one long-term answer, the Center has been working with the State college at Presque Isle to establish a new major in the behavioral sciences. Vickers thinks this would be an important step toward making the institution a real community college, in the sense of a college that focuses on the community rather than the world. He says: "We want to help the kids going to school see that they can meet all the challenges to be found anywhere else in the country, right here in Aroostook County."

Six members of the Center's staff are now teaching courses at Presque Isle—in social psychology, in community psychology, and sociology—and the psychologist in the office at Fort Kent is teaching at the State college in that town. "Our intention is to use the community as a laboratory for the classroom," Vickers continues. "We want to try to turn the kids back into the community rather than simply educate them—whatever that means—and let them go in whatever direction they choose."

Looking Ahead

Plans for the second year included these important increases in the Center's consultation and education—or indirect service—capability:

- A second psychiatrist, so that both psychiatrists would have time to work in the community, consulting with general practitioners and taking part in some of the Center's workshops for other professional people. The first psychiatrist had been giving full time to inpatients and to consultation with the Center's other therapists at Fort Fairfield and the branch offices, which he visited once a week.
- Two educators, with doctorates, who have specialized in problems of learning, to augment the school consultation team. This team has consisted of a psychologist and two social workers. When it has been expanded as planned, each member may have time to work directly at the Center with some of the children—those with the most severe problems—who have come to his attention in the schools.
- Extension of its consultation services to include help for probation officers and the staff of nursing homes. The Center also plans to improve its work with alcoholics, now limited to drying them out and providing some counseling. A proposed program would establish a rehabilitation center where alcoholics would live for a time while acquiring the strengths and skills to start another way of life.

Vickers sees a need as well for special homes for troubled adolescents. These might be existing homes, headed by understanding, emotionally mature parents, in which delinquent youngsters might live while being helped to meet their problems. Aroostook County now has only two ways of handling a delinquent—to send him to a training school or back to his own home. The Center is working with other agencies in the hope of providing a third and often better choice.

Looking back over his first year, the director said one of the most important things the staff had learned was that many patients can be treated in groups. "So we are moving toward more group therapy," he said. "This is giving us more time to get out into the community and develop its resources, which is really what we ought to be about."

4. Down East: A Heavy Reliance on Volunteers

The catchment area of the community mental health center at Bangor, Maine, runs from the lower Allagash River, in the heart of the State's wilderness region, south to Bar Harbor and the rest of Mt. Desert Island, and east to Eastport, where the sun first shines on the U.S. It covers 12,000 square miles and is among the country's largest. The majority of its 216,000 residents live in communities of less than 5,000 people. They depend on farming, fishing, lumbering, or factory work—mainly in paper mills. Though countless visitors lend an air of prosperity in the summer, the region is economically poor and has been designated, to enable receipt of Federal grants, a poverty area. A third of the Center's patients are on welfare. The suicide rate is three times the national average.

In this Down East region, the Bangor agency, known as The Counseling Center, has made noteworthy progress in putting services within the reach of everybody. To do so it has enlisted many volunteers—more than 400 early in 1972, including those the Center calls its "community representatives." The administrative staff, convinced that volunteers are essential to the most effective functioning of a mental health center in such a territory, intends to enlist even more of them.

During a recent 6-month period, the Center served more than 2,000 patients, of whom it hospitalized about 100, cared for 30 in its partial hospitalization program at Bangor, and treated 1,900 as outpatients. Of the total, approximately 60 percent were from rural areas and small towns.

The Service Network

Until the Counseling Center opened its doors in 1969, the area was without mental health services except those of the State hospital at Bangor and of two small agencies, their services largely limited to Bangor and vicinity, which merged to make the area-wide Center possible. Now, in addition to headquarters facilities, the area is served by six full-time regional offices and eight outreach offices, which are open weekly, biweekly, or by appointment. This network puts some type of outpatient service within an hour's travel of almost everyone in the area.

Persons needing hospitalization still go to Bangor but now can be served by the agency's 14-bed unit at Eastern State Medical Center, which is a large general hospital, and not alone by Bangor State. The Counseling Center is trying to persuade the other general hospitals in its area—a dozen small ones—to take psychiatric patients on at least a limited basis: no more than one at a time and for no more than a day. Says Richard T. Lamping, the Center's executive director: "In many cases, if you could get a person who had had some sort of psychotic break into an inpatient unit and put him to sleep over night, the next day he could go home. If you have day care and outpatient services for people after they leave that one-bed unit, people would not be dumped into the State hospital. But our small general hospitals still resist taking these people." He reports progress: four of the hospitals, as against one when the Center opened, now accept alcoholics.

In the case of patients admitted to Bangor State, the Center has generally lost sight of them, if indeed they ever came to its attention, because this hospital preferred to operate quite independently. However, after 2 years of negotiations with Maine's Bureau of Mental Health, the Center expected that it would soon begin working in the hospital with catchment-area patients before they were discharged and would then provide whatever services might be needed to help them remain in the community. And it expected that more persons seemingly in need of hospitalization would be referred to the Center instead of being sent directly to Bangor State. Under such arrangements, coupled with the needed additions to its staff, the Center believes that the State hospital's population of about 1,000 can be reduced by several hundred in a year's time.

Staff, Quarters, and Budget

The Counseling Center is an excellent example both of the diversity of personnel manning rural mental health centers and the diversity of structures in which the centers are housed. The executive director is a social worker who has specialized in community organization—that is, in planning programs and raising funds for community agencies—in many parts of the country; this is his first job with a mental health organization. Of the three regional area directorships, each serving two offices, one is filled by an administrator, one by a former teacher and school administrator, and one by an ordained clergyman and former teacher. Two of the clinical directors in these areas are psychiatrists; one is a psychologist.

The Center's headquarters are a cluster of converted barracks at the former Dow Air Force Base, now Bangor International Airport. The barracks, owned by the University of Maine, are rent-free, but utilities and maintenance cost about $14,000 a year. Three of the regional centers occupy old houses, one has offices over a Main Street department store, one is in a hospital, and one in a small building inherited from an earlier mental health agency. Of the outreach offices, four are in hospitals, two in churches, one in a private school, and one in a staff member's home.

On the staff are about 85 professionals employed full time, including three psychiatrists. A dozen other professionals work part time. One of the psychiatrists, who is assigned to the two northern regional offices, manages to cover his territory because he flies his own plane, equipped in the summer with floats and in the winter with skis. Instead of mileage, he collects a time-in-air allowance. The executive director and several other staff members are taking flying lessons because, as Lamping says, "The distances are really impossible unless you have some fast way of getting places." Twice a month the regional and home office staffs meet at Bangor. Each regional office has its own advisory board, one or two members of which are members also of the Center's board of directors.

The budget for the fiscal year 1972 was $1.2 million. Of this, about $303,000 came from an NIMH staffing grant and $360,000 from an NIMH alcoholism grant. State appropriations were set at about $235,000, and town appropriations, which have been steadily rising, $24,000. (In 1971 some 20 towns voted appropriations based on about 50 cents per resident. Approximately 15 other towns were not approached because they are served by the United Fund, which allocated $52,500 to the Center.) Patients' fees, more than a third of the total paid by Medicaid, were estimated at $140,000, and contributions from Mental Health Associations in the area at $30,000. Contributions from industry for the alcoholism program were estimated at $40,000. The Center also counted on $21,000 in endowment income from gifts to its predecessor agencies.

Volunteers as Community Representatives

To cover its wide territory, the Center's administrative staff is alive with projects and ideas for using volunteers and paraprofessionals. Most volunteers serve as community representatives, but about 75 help man the emergency service, conduct therapy, or engage in a variety of other activities.

The community representatives include businessmen, clergymen, nurses, policemen, teachers, doctors, town officials, agricultural extension workers, welfare personnel, lawyers, and housewives—altogether about 350 persons, in almost 200 towns and settlements, of some prominence as community caregivers. In classes held throughout the area, they have been informed about the Center's services and given basic training in crisis work, such as handling a drunk or a would-be suicide.

These volunteers are viewed as persons who may themselves be able to help an individual in crisis, who can mobilize whatever community resources there may be, and who are ready to seek professional advice through the Center's toll-free telephone counseling service, which is available everywhere in the catchment area. The volunteer representative acts in response both to calls from his neighbors and to calls from the Counseling Center apprising him that a neighbor needs help. His very presence gives him an important public relations role.

A year after the community representative system was established, in 1970, the executive director reported that while it had accomplished some good—he recalled that one representative had recently talked a man out of trying to commit suicide—its benefits were still largely potential. Some members of the Center's professional staff have resisted the system, he said, because the use of little-trained volunteers seemed to imply that much of the professionals' own training had been unnecessary. Also it had become clear that a full-time staff member was needed to develop and improve the system. This person was employed late in 1971. He aims to build a corps of 500 representatives trained in the fundamentals of mental health work. "I've come to believe such a system is the only kind we can use in an area like this," Lamping said. "We seldom refer people to another agency because generally there isn't any other agency. We have to put people in the care of other people. We've got to organize these other people to handle them. I think this idea holds out more promise than anything else we've got hold of."

At Work in the Emergency Service

Volunteers are now a key element of the Center's emergency service. In the beginning this was activated by a telephone answering service, which relayed off-hour emergency calls to professional staff members. Since February, 1971, however, a staff of volunteers and paid paraprofessionals has manned local and long distance lines in a small office in the Bangor headquarters 24 hours a day, providing access to the services of the Center everywhere. When appropriate, the staff refers callers to other agencies or individuals, and it offers sympathetic and informed advice to troubled persons not ready to accept professional help. The service has been widely publicized as "Dial *HELP*—Telephone Counseling for Personal Problems and Emergencies." In Bangor and vicinity the caller dials 947-HELP; elsewhere, a toll-free, long-distance number. The workers on duty receive calls on these lines directly; during the day they also receive from the switchboard any initial requests for service.

About 30 persons have been trained as "24-hour workers." Eight work at night and are paid, under one of two Federal programs—Operation Mainstream, for helping socially disadvantaged adults enter the health and welfare fields, and Work Study, for college students. The rest, who work the day shifts, are unpaid volunteers from many walks of life.

From 20 to 40 calls a day come in over the toll-free lines from the rural areas. The callers are mainly people who have problems with marriage or alcohol, or both; three or four times a week they are people who are thinking of suicide. In at least three cases during the first half year, the new service is credited with having saved lives.

A similar project addressed to teenagers, manned by teenagers, and known as "REACH OUT, the Teen Hotline" went into operation late in 1971. Twenty-three trained young people were operating it, and another 18 were in training.

Volunteers as Therapists

The Ellsworth regional office, under the direction of a clinical psychologist, Dr. Thomas Reif, uses volunteers even as substitutes for professional manpower. Recently 15 volunteers there were providing a variety of services, from home health care to new mothers on up the ladder to dynamic therapy. One woman was being used as a mother figure for a borderline psychotic girl 2 hours a day, 5 days a week. Another was working with a troubled adolescent, recently returned from a long series of shock treatments in the State hospital. A third was running an activity group in an outlying school and giving individual attention to children with special problems. Several volunteers were working with the psychologist in a weekly group session for patients.

Volunteers participate at the level they choose, Reif says, and with the skills they have. They are all housewives and mothers, and some hold paid jobs. They are trained by actually working with patients, under Reif's supervision, and by participating in discussion groups led by Reif 2 or 3 hours a week.

The Ellsworth office—psychologist, social worker, secretary-receptionist—served 70 patients during the winter of 1971, of whom the volunteers were involved with 17. All of these were reported to have shown definite improvement attributed to the volunteers' activity.

For Day Care: Paraprofessionals With a Degree, and Volunteers

Though the Center now provides day care at its central headquarters only, and therefore only for urban patients, it expects to extend it within a few years to the regional offices—again through the use of volunteers. Its planning is built in part on a joint project of the Center and the University of Maine to train mental health paraprofessionals. Under this project, which began in 1971, the University's Bangor campus offers a 2-year program leading to an associate of arts degree in mental health technology. Members of the Center's staff are teaching many of the courses, and the students are observing the Center's operations and participating in some of them—easy matters because the University occupies barracks adjacent to those of the Center. The 14 students the first year included not only recent high school graduates but also older persons, among them a former airplane flight instructor and a housewife.

The 2-year degree will come to be considered as important for mental health paraprofessionals as the Ph.D. for psychologists, Lamping thinks. He predicts each of the holders will have a number of job offers from State and general hospitals, welfare and other social agencies, and mental health centers. Lamping hoped to hire some of the University of Maine graduates as day-care supervisors in regional offices. Their staff would be six or eight volunteers, each working perhaps a day or two a week. Occupational and recreational therapists from the main office would help lay out the program, and other professionals would occasionally take a look at the operation. But the paraprofessional would be in charge.

New Approach to Alcoholism

Misuse of alcohol is probably the most prevalent mental health problem in the Center's area. To combat it, the Center, with the help of an alcoholism grant from NIMH:

- Directs a 30-bed Alcohol Rehabilitation Center in Bangor in a building that used to house tuberculous State hospital patients, and has two halfway houses for alcoholics—both in rural communities.

- Has added 10 alcohol service specialists to its staff, five of them assigned to regional offices.
- Is in the process of organizing a corporation—an office cleaning company—to employ recovered alcoholics. When an alcoholic is ready for a job, he will be hired by the new corporation so that he can earn a living and eventually—after 6 months, perhaps—find work elsewhere with the help of a reference certifying that he is a decent, trustworthy employee. Frank Dennis, director of alcoholism services, points out that even a recovered alcoholic faces an almost insurmountable problem: lack of references.
- Initiated a program late in 1971 to serve organizations, primarily industries, having alcoholic workers they would like to rehabilitate rather than fire. The program is conducted at the Industrial Residential Treatment Center, which is an old hotel in East Millinocket—a lumber and paper mill center 65 miles northeast of Bangor—that the Center has leased and reconditioned to provide comfortable quarters for 12 men. On the facility's staff are two alcohol service specialists as director and assistant director and an industrial psychologist, all of them full-time; a clinical psychologist from the nearest regional office and the flying psychiatrist, both part time; and housekeeping and maintenance personnel. "A home rather than an institution," the Center tells industrialists, "the facility offers a semiprotective atmosphere in which the problem drinker and other guests work together with a positive spirit for recovery." The program includes medical care as required, group and individual therapy, counseling, educational films and talks, hobbies, access to Alcoholics Anonymous meetings, "and a lot of understanding." Rehabilitative efforts are tailored to fit the needs of the individual. Clients usually stay 3 weeks. They have included labor union officials as well as men from industry.

A brochure entitled "To Stand Along Side," describing the project, has won Gil McDowell, the Center's director of information services, a national award for its design and content.

Consultation Services

During the Center's second year, staff members traveled to central locations to give 500 teachers a 15-week course on mental health, which dealt in particular with the disturbed child in the classroom. The teachers, who got State credit for attending, were a third of all those in the area and came from 20 of the 37 school systems. On the Center's staff are two full-time school mental health consultants who provide, among other services, seminars on mental health to school personnel, consultation with teachers on the mental health of individual students, and assistance to schools in making referrals to the Center. The Center has contracts with a dozen school systems and serves several others even though they cannot pay.

The Center also employs two full-time clergymen—a Catholic priest and a Presbyterian minister—to consult with the clergymen of the region on the mental health problems of their parishioners. These counselors also develop training programs for groups of clergymen and consult with the Center's therapists about patients who have problems of conscience and religion.

During one recent month there were 325 hours of consultation to school teachers and administrators, 225 to clergymen, 20 to police and court officials, 45 to staff members of other agencies, and 25 to physicians.

Homemaker Health Aide Service—And Beyond

The Homemaker Health Aide Service is a cooperative effort of the Center and the Maine Department of Health and Welfare to help a family or an individual in his home in time of need. In Bangor and the regional offices the Center supervises close to 20 aides. These are mature women who have raised families of their own and who have been given courses in home management, nutrition, budgeting, safety, personal care, and mental health.

Lamping points out that the homemaker service was inherited from one of the Center's predecessor agencies, the Family and Child Health Services of Bangor. In justifying its retention by the Center and its growth throughout the catchment area, he points out that home health care, especially if the cost were met through Medicaid, "would keep a lot of people who are now dumped into State hospitals out of those hospitals."

He believes, too, that the Counseling Center, and probably many other rural mental health centers, is destined to assume wider responsibilities for the health of the people it serves. It seems to him that the Center is already on the way to becoming a health delivery system. As an example, Planned Parenthood wants to provide family planning services through the Center's regional offices. And, at the request of the State and with State financial aid, the Center is writing a developmental disability plan for its catchment area. The goal is to provide a service system for the neurologically handicapped, including the epileptic, the cerebral palsied, and many of the retarded.

"I would guess," Lamping says, "that we would eventually be the vehicle for providing almost all public health care. It's too expensive to create many structures like the Center." As further evidence of a move toward centralization of services, he points to 1971 legislation under which Maine's Department of

Mental Health and Correction and its Department of Health and Welfare are to be merged and become the Department of Human Services.

5. Prairie View: Making the Whole Community Therapeutic

When the Prairie View Mental Health Center, in Kansas, began operating under the NIMH program in August, 1966, its inpatient and emergency services were already 12 years old and its outpatient and day care programs not much younger. For this community mental health center has evolved from a small private, forward-looking psychiatric hospital—also known as Prairie View—established in 1954 by Mennonite Mental Health Services, Inc., an activity of the Mennonite Church. As a community mental health center, it serves a three-county, predominantly rural area of 67,000 people, who live within a radius of 50 miles. It also accepts patients from other parts of the State and the region. Recently it instituted a Growth Services division, geared particularly to the needs of the nonpatient population, as individuals and as organizations.

An analysis of community mental health centers by the American Psychiatric Association has cited Prairie View for the high quality of its services, and in 1968 the same association conferred its highest achievement award on the Center for its comprehensive community program. Members of the Center's staff are frequently called in to consult with other mental health centers or with groups planning new centers.

Although the Center is under the auspices of the Mennonite Church, it is fully responsible to the community. It serves patients from a variety of denominations—more than 15—and from none at all. In a recent year the largest groups served were Catholics, Mennonites, Methodists, Baptists, and persons reporting they had no religious affiliation.

The process of changing from a private psychiatric hospital to a mental health center began about 4 years after the hospital opened and coincided with a decline in the number of persons for whom full-time hospitalization was sought. From an emphasis on inpatient services, the staff turned to considering what programs might be developed to serve the entire area—its schools and other institutions, its private practitioners and other caregivers, and its residents in general.

In the early 1960's the State established a mental health program that encouraged county commissioners to contract for the services of mental health facilities. One result was an agreement under which Prairie View Hospital began providing outpatient, consultative, and some educational services for residents of Harvey County, where it is located. About the same time, as reported in Chapter III, the hospital received an NIMH demonstration grant to provide aftercare services to all Topeka State Hospital patients returning to their homes in Harvey and the two other counties making up the present community mental health center catchment area. Service contracts with these other counties followed. Then came NIMH construction and staffing grants to help complete the change into a comprehensive mental health center.

Located on a 55-acre plot on the outskirts of the small town of Newton, in the central part of Kansas, the Center looks out in every direction over the Kansas prairie. Physically, it is a cluster of one-story, low-lying buildings, with a pleasing noninstitutional appearance. Near the cluster are scattered trees, which shelter picnic tables in the summer; farther out, a small pond, a tennis court, a baseball field, a five-hole golf course, and space for gardening.

The original hospital building is a long, ranch-type structure with overhanging roof. Just west of it lies the office and community service building, constructed with the help of an NIMH grant of about $200,000 and opened in 1967. It houses the clinical and administrative offices and provides space for education and consultation activities. A small building nearby that used to serve outpatients has been remodeled into a cheerful and spacious day hospital, with a group room, recreation space, and a quiet room. An adjacent building houses the arts and crafts center and a sheltered workshop type of operation that the Center calls its industrial therapy program. The newest member of the cluster is a recreation center and gymnasium, opened in 1971 and used by townspeople as well as by inpatients, particularly adolescents.

The Center has a branch office in a neighboring county, which serves 150 persons a year. Also, it is affiliated with Meadowlark Homestead, a facility for extended care that operates also as a halfway house for the Center. Located about a mile and a half north of the Center on a 100-acre farm, Meadowlark is about as old as Prairie View. The two became affiliated in 1968 under an agreement providing that any person eligible for treatment at one facility is also eligible for treatment at the other. Meadowlark can accommodate 26 patients.

A visitor from the East Coast, well acquainted with mental health facilities across the country, once remarked that if he ever fell sick he hoped he could get into Prairie View. For there he had found an expectation, both in the light and cheerful buildings and in the outgoing and warm but purposeful attitudes of the staff, that was conducive to getting well. In fact, there was an expectation that you really were well.

Why a visitor or a patient might feel that way was explained in a recent issue of the Prairie View Newsletter edited by Marie Snider. "Having problems doesn't mean a person is mentally ill," she said in an article describing the center and the tenets of its staff; "it simply means he is alive. But there are times when life's problems become overwhelming."

Programs, Patients, Staff

For persons whose problems have become too great for them to cope with unaided, the Center offers these direct treatment programs:

Outpatient. Here a therapist helps an individual to explore effective ways of meeting difficulties. The therapist may also prescribe family therapy, married couples' therapy, group therapy, psychodrama, play therapy, or drug therapy. During 1971 the Center admitted more than 1,200 outpatients, about a third of them children and young people up to the age of 19.

Day Care. Under the supervision of a psychiatric nurse, this program serves persons, including some who have been hospitalized, who need more support than they would receive as outpatients. The day center patient has access not only to the therapies available to the outpatient but also to art, recreational, and industrial therapy. About 200 persons were admitted to the day center in 1971. The median length of stay was 34 days; the average, 65. About one-third of the patients attended 5 days a week; the others, less frequently. At any one time there were about 30 on the roster and 15 in attendance.

Inpatient. This program aims to provide a 24-hour therapeutic community—a milieu in which each patient can come to know himself through his interaction with staff members and other patients. Each patient becomes a member of a treatment team that includes other patients, psychiatric aides, a nurse, and a therapist; the teams meet daily for a period of group interaction. Patients are encouraged to take as much responsibility as possible for helping themselves. Once a week, patients and staff meet to help plan hospital activities and discuss problems of existing together in a small, special community. Also scheduled are creative arts, psychodrama, and industrial therapy. The Center admitted close to 300 inpatients during 1971, for a median stay of 30 days and an average stay of 48. Roughly a third of the inpatients, the largest of the age groups, were under 19; many of these were treated for drug abuse. Usually, almost all of the 43 beds—which are in either single or double rooms—were occupied.

Altogether there were 1,700 admissions, a total of 1,200 individuals, for direct services in 1971. Close to two-fifths of those admitted came from outside the catchment area, for Prairie View accepts patients from much of the Midwest. A number of day-care and even outpatients from distant areas take up residence in the community while being treated. During Prairie View's first year as a comprehensive mental health center, admissions totalled 700; during the hospital's first year, not quite 200.

Administrator of the Center is Elmer M. Ediger, who has had extensive experience in community hospitals. He was the administrator of Prairie View Hospital during the years it functioned as a private institution, and it was he who guided the metamorphosis from hospital into community mental health center.

The Center's fulltime staff includes four psychiatrists, six psychologists, 10 social workers, nine registered nurses, 25 psychiatric aides, an occupational therapist, two school teachers, three health administrators, and a clergyman. Among the part-time personnel are four occupational therapists and three registered nurses. Some 60 volunteers in a recent year served a total of more than 4,000 hours in a variety of roles.

Work Therapy

One of the unusual features of Prairie View's direct services is the industrial therapy program, in which inpatients and day patients have an opportunity to do paid, productive work—making seat pads for tractors and golf carts. More than 16,000 a year are turned out under contract with a local manufacturer. During one recent year, 230 patients took part in this program. The hourly rate, paid slower workers, was 80 cents. But inpatients who worked at piece rate averaged about $1.50 an hour; outpatients, about $1.80. In addition to the seat pads, they made a mile of church pew cushions. The contract brings in $73,000 a year, which goes for wages and operating expenses. For young patients, this is often their first job; for older patients, the program provides needed structure, practice in work skills, and experience in on-the-job relationships so that when they leave the hospital they can enter or reenter the area's work force.

The creative arts program, too, is designed not simply to keep patients busy but to give them the satisfaction that comes from producing something of esthetic or practical value. Efforts are made to find and develop individual skills and talents. Silver buckles, copper jewelry, and other articles are made and sold, part of the proceeds going to the workers and the rest being used to help pay for their treatment.

Working for the Community's Mental Health

The Center has been concerned not only with how to provide treatment for persons who have experienced disabling emotional distress but also with how to provide a climate for better mental health in the entire community. It works to make the community itself—and not alone the hospital and the day care center—a therapeutic community.

Toward this end, the Center:

- Sponsors or cosponsors a variety of training programs in human relations. Among these are (a) workshops dealing with interracial relations, the role of women in community life, and the role of supervisors and managers in industry; (b) discussion groups on community activities, particularly those attempting to meet the needs of lower-income people; (c) plays and films on problems of family life; and (d) courses on child development and family relations—attended during one recent year by 250 persons, meeting in small groups half a dozen times.
- Cooperates in one county with United Church Women to provide a practical, homemaking type of support and education to mothers in low-income groups, and in another county supports discussion of family life problems by representatives of similar groups.
- Offers the Prairie View Forum Series, open to the public, designed to stimulate discussion about current issues in religion and mental health.
- Designates staff members to meet monthly with the personnel directors of several industries in the area to discuss employees whose severe emotional difficulties—commonly manifested by alcoholism—have affected their work. These monthly conferences lead to arrangements for such persons to stay on the job while receiving any necessary treatment or to return to work after a period of hospitalization.
- Works closely with LINC (Leadership, Inc.), an autonomous body set up both to train individuals for community leadership and to coordinate their efforts. One important activity is a series of Community Leadership Development Laboratories.
- Provides consultation to courts, welfare agencies, a medical clinic, an employment agency, homes for the aged, colleges, and schools.
- Promotes a close relationship with the area's churches through the Center's chaplain, who sees individual patients, works to have the pastors of inpatients visit them, offers informal and free consultation, and, with a therapist, conducts a monthly Pastors' Consultation Seminar for clergymen who have parishioners in the hospital.

Among other activities for the benefit of the community, the

Center has offered a workshop for married couples, a therapeutic group for under-achieving students at one of the colleges in the area, and two projects for teachers and prospective teachers—a "Sex Education Workshop" and a course, "Emotional Problems of Children," both of which earned their participants college credit.

Prairie View also provides continuing education projects for members of its staff and other interested professionals. These have included human interaction workshops, training in psychodrama, workshops on learning disabilities, and refresher seminars dealing with psychotherapy techniques. Each summer, under the auspices of the Association for Clinical Pastoral Education, the Center offers a 10-week clinical training program for clergymen and seminary students. Graduate social work students from the University of Kansas come to Prairie View for 9 months of field work, and students from two Kansas schools of nursing complete their psychiatric affiliation there.

For many of the community services, the charges are below cost. However, the Center receives substantial contributions from some of the organizations aided. As reported in a recent study, it operates on the unspoken philosophy that "if you cast your bread upon the waters it will come back cake." (57) And it keeps the welcome mat out. During a recent year it was visited by 65 groups—mainly high school and college students and professional groups—totalling 950 persons. This does not count individual visitors, the local physicians who go to the Center monthly for a videotaped presentation of some facet of mental health work, or any groups who visit it as part of the community services program.

Growth Services

To coordinate and expand activities like those summarized in the preceding section, the Center in 1971 established the Prairie View Growth Services Division. The general aim is described as "setting in motion new processes for growth for both individuals and organizations"; it could also be described as the prevention of mental illness and the enrichment of life. The division's director is a social worker; the assistant director is the staff clergyman. Among other members are the Center's director, its director of research, and staff members specializing in psychodrama and learning disabilities. Other staff members are called upon as needed.

The division sponsors workshops and other programs at the Center to promote either personal or professional growth. It also serves organizations, whether or not within its catchment area, that ask for help on such matters as staff or community development, organizational effectiveness, and assessment of goals. Recently it sent a consultant to Lincoln, Nebraska, to help that city's school system prepare for a self-study of the system's effectiveness. Says the assistant director: "The church believes that people can learn to live life more abundantly, and I believe that's what the Growth Services Division is concerned with as well. This suggests, for instance, that we have to look at our organizations, our business functions, our decisionmaking as well as our concern and love for other people."

The division hopes to become self-supporting.

Programs for the Schools

Prairie View's work with the schools—a major part of the services supplied under the contracts with the three counties—is particularly comprehensive. It includes individual case consultation, a screening program for kindergarten children that uses measures of both physical and mental health, and a training program that helps teachers identify children with emotional problems and acquaints the teachers with remediation techniques that may be used in the classroom.

A remedial school for children with learning difficulties has been conducted by the Center with the cooperation of the local schools since the summer of 1970. Children divide the day between the Prairie View school and their regular classrooms. The Center and the local schools also cooperate in providing classes at Prairie View for inpatients. During a typical year about 50 adolescents are enrolled in some type of school program. A dozen attend classes at Prairie View for credit at Newton High School; another dozen are tutored, their assignments being sent from their home school and the cost being shared by the Center and the State; six or eight go to public schools; and the rest attend classes without credit.

Several therapeutic groups have been organized for young people in the community. One for adolescent parolees is led by a Center therapist and either the probate judge or the probation officer. Another is for participants in the OEO's Youth Corps program; a third, for potential high school dropouts. The Center also provides consultation to the teachers and the parents of children in the Headstart program.

Money and a Few Problems

To avoid overdependence on Federal money, Prairie View's board of directors decided that no more than 15 percent of the budget should come from Federal sources.

In the year ending in November, 1970, the Center spent about $1.25 million, as against receipts of about $1.28 million. Fees paid by the patients were the largest source of income—$634,000. This represents an unusually high proportion of total income and reflects the admission of patients from outside the catchment area. Medicaid, Medicare, and private insurance amounted to $317,000. The Center received $158,000 from NIMH that year as a staffing grant, $16,000 from the State, and $130,000 from the three counties contracting for its services. Other receipts included $14,000 in gifts and $13,000 from investments.

Limitations on Use of County Funds

The commissioners of each county in the catchment area appropriate funds for mental health use in their respective counties. Each county has a Mental Health Service Board to coordinate the program and oversee the use of the funds. Representatives from each board constitute a tri-county board, which determines what percentages of funds shall be allocated to outpatient, daycare, and consultation and education services. The Center's administrator is the tri-county board's executive secretary.

To residents of the area who are within a specified income limit—in 1972, this was raised from $6,800 to $10,000 a year—both outpatient and daycare services are available on a sliding scale, according to ability to pay. A program of home visitation is also included in this county system of mental health services. It enables some persons to avoid hospitalization and provides follow-up care to others who have been discharged from the State hospital.

The system presents some problems. For one thing, county funds may not be used for full-time hospitalization except at a State hospital. For another, these funds provide no help for the families who are beyond the top income limit.

Transportation

The residents of Prairie View's catchment area are unusually fortunate because driving time to the Center from the most distant point is only an hour. Even so, transportation is a problem, reflected in the counties' differential usage of Prairie View's services: patients from the home county are far more numerous than those from the other two. A volunteer transportation service from one of the counties operated well for a time but then broke down, partly because of administrative difficulties and partly because of the need for more volunteers who could take on considerable responsibility.

Looking Ahead

Prairie View has set as its highest priority the development of programs (1) to assist the "natural helpers" of its catchment area to acquire a grounding in mental health principles and practices and (2) to help modify the root causes of poverty, including educational disability from whatever cause and feelings of inferiority and hopelessness. It hopes soon to develop a child advocacy program, which would coordinate existing services for children and young people throughout the area, eliminate overlap, and provide additional needed services. These include a halfway house for drug abusers as a means of easing them back into the community after treatment in the inpatient program. The development of drug abuse treatment on an outpatient basis is also under consideration as a way of lightening the load on the inpatient service. Prairie View feels a need as well to expand its services for elderly people.

Some years ago Elmer Ediger, the administrator, asked himself if the Center's interest in providing service to the individual and the community was in keeping with the Center's church sponsorship. He answered his own question like this:

"Our program is focused on meeting human needs in the best way we can. Our staff members are selected inasmuch as possible for their skill, their character, and general sense of kinship with the church. Our language is largely that of mental health professionals and the people we serve. We are immersed in trying to use our total selves to help people. Though we do not say it often, I believe ours is a remarkably appropriate church-sponsored effort to love, to represent faith in life, in God, and to undergird virtues we believe God wants in society."

To this he can still say *Amen.*

As the patients become persons instead of anonymous objects, the staff members also become persons instead of functionaries.

—*Jerome D. Frank, M.D.*

CHAPTER VI

STATE HOSPITALS WITH RURAL PATIENTS: CHANGES FOR THE BETTER

On an average day in 1972, the population of State and county mental hospitals was approximately 283,198. It would have been 777,000 if the long upward trend had continued instead of being reversed in the middle 1950's.

True, admissions to public mental hospitals have been increasing, but releases have been increasing even faster. For example, in 1963 there were approximately 284,000 admissions and 295,000 releases, including deaths—a difference of 11,000. Eight years later the admissions totalled about 415,000 and the releases, 446,000—a difference of 31,000.

Many interrelated factors have contributed to the decline of the population in public mental hospitals. Among them are:

- New methods of treatment that came into use during the 1950's—principally milieu therapy, which seeks to make the atmosphere of the entire hospital conducive to recovery, and chemotherapy. (The new therapies have had both direct and indirect benefits. They have made patients better, and they have also raised the expectations of hospital staffs as to the outcome of treatment, thereby further raising the staffs' effectiveness.)
- New treatment objectives under which emphasis is placed not so much on a cure—or, failing that, custodial care—as on the ability to function independently or partly independently in the community.
- New admissions policies under which many State hospi-

tals screen certain types of potential patients to determine if their needs can be met more appropriately in nursing homes, foster homes, sheltered workshops, or other community facilities rather than in the hospital.

- The increased availability of community-based programs, such as mental health centers, psychiatric services in general hospitals, outpatient clinics, and day care facilities. (Such programs reduce both the need for hospitalization and—by providing aftercare services—the stay of those who must be hospitalized.)
- The expansion of health insurance to include payment for mental health services, with the result that many people in need of such services can afford to obtain them in the community.
- Changing public attitudes about mental illness and about people in need of mental health services.

In many State hospitals the application of more effective means of treatment and the adoption of more enlightened goals and policies have depended upon—or at least been spurred by—two NIMH programs that have worked since 1964 to raise the capabilities of public mental institutions. One of the programs is designed to improve the functioning of such hospitals by helping them provide new services and apply new policies; the other, by helping them provide inservice staff training. This chapter presents examples of the two programs at work in hospitals serving largely rural populations.

1. The Hospital Improvement Program (HIP)

Under this program the Institute offers grants and advice to State hospitals desiring to meet a specific need—for instance, a rehabilitation program for long-term patients, a center for children or for elderly persons, treatment for alcoholics, or regrouping patients according to where they live rather than according to such standards as how they have been diagnosed, how they behave, or how long they have been in the hospital.

The specific amount of the award for each project approved by the National Advisory Mental Health Council will be determined by the Regional Health Director or his designee. Support for any one institution may not exceed $100,000 for any 1 year, including indirect cost at negotiated DHEW rates, if not waived.

The HIP program began in 1964. By 1973 the Institute had made grants to about 180 of the 287 eligible mental hospitals, meaning those that are part of the States' mental health programs. The grants totalled approximately $66,500,000. Of the hospitals aided, the Institute identifies a little more than 20 percent as rural and as serving a large rural population, because they are located in rural counties. This classification basis greatly understates the benefit of the HIP program to rural people. For example, from one to six HIP grants have been awarded in Alabama, Georgia, Indiana, Maine, Montana, and Nebraska, yet none of the eligible mental hospitals in these States is considered rural. In many States at least some of the hospitals with HIP grants are located in urban communities but serve rural as well as urban populations.

Tens of thousands of patients have been admitted to HIP projects. An analysis covering the first 4 years of the program shows that patients had been hospitalized for an average of almost 5 years at a cost of nearly $3,000 per year per patient. After an average stay in a HIP project of less than a year, at an additional cost per patient of only $621, more than 50 percent of these patients were sufficiently improved to go home or be placed in nursing or boarding homes in the community.

Thousands of rural patients have been directly affected by the program. But virtually all the HIP projects have had an influence far beyond those patients and staff members immediately concerned. The lessons learned—mainly that with appropriate care even patients considered hopeless can improve, often to the point of at least a more nearly independent life outside the hospital—were picked up and applied by staff members in other parts of the institutions. Further, many projects have served as training programs not only for hospital personnel but also for students—medical, nursing, social work, education—from colleges and universities of the area. Frequently, too, representatives of other State hospitals have inspected a HIP project with the intention of trying something similar in their own institutions. More than 75 percent of the programs developed with HIP grant support have been fully incorporated into the hospital with State support.

Of the projects summarized here, a few have been completed recently, most are continuing.

Hope and Help for the Long-Term Patient

The revolution in mental health care is forcing most State hospitals to reexamine their roles and to change their programs. With the acutely ill being treated in the community, or, if they reach the State institution, intensively treated and soon discharged, the question of the chronically ill—who have long been neglected as impossible or too difficult to help—has pushed to the fore. The hospital's problem is to shift from the custodial role with these patients to the therapeutic. As one hospital administrator wrote, in requesting aid for a program to treat such patients:

"It becames increasingly difficult to reduce our census further (it had come down from 2,300 to 1,700) because we have no effective methods of dealing with long-term patients." He also said: "A group of our patients may never go home, but it is essential that we seek to raise these individuals to the highest level they can attain."

Statistics covering the first 4 years of the Hospital Improvement Program suggest how profitable it is—from the money standpoint, as well as the humanitarian—to set up programs for the chronically ill. People in the average HIP project for these patients had been in the hospital almost 12 years; but in little more than 10 months, 70 percent of them, or a total of 6,500, were able to take up an independent or partly independent life in the community. Without the intensive therapy or placement services made possible by HIP grants, most of these patients would have remained largely forgotten in the back wards of State hospitals.

"*Activating Therapy*"

One of the many institutions using HIP funds to improve the care and treatment of the chronically ill is Fulton State Hospital, at Fulton, Missouri. (*58*) This hospital serves an area of farms and small towns in the North Central part of the State.

Aided by the funds from NIMH, the hospital undertook what it calls "activating therapy" for chronic patients, in particular those who have become so immobilized in the course of their illness and hospital stay that their spontaneous activity is little more than sitting or rocking in a chair. The project's goal is to help such patients become increasingly responsive to life and avail themselves more fully of hospital programs directed toward their recovery and rehabilitation. The hope is that many eventually can be discharged from care or placed in a nursing home. Up to 200 patients—men and women from four wards—are involved in the program at any one time. They are physically able but inactive.

All patients in the project attend "activity classes" given by some 20 "activity aides" 5 hours a day, 5 days a week. Among the classes are: library, which includes reading newspapers, magazines, and books, discussing topics of interest to the class, and working on the HIP Gazette, the project's house organ; primary education—classes at different grade levels to help patients renew academic skills or acquire skills they never had; arts and crafts; good grooming; home economics; and woodworking.

To provide relaxation and entertainment between classes, there are "ward groups," whose activities include cards, checkers, croquet, baseball, and horseshoes. There are also a nature study club, a garden club, and a sports group, to which anyone interested may belong (though the garden club, with a 25-member limit, has a waiting list). A dozen patients at a time spend half a day in "escort service." They escort other patients who need help in getting to some of the activities or to other hospital services. Another 20 patients, volunteers, go to the geriatrics building each meal and help the nursing staff feed patients who cannot feed themselves.

An activity council whose members are patients—three from each of the four wards in the project building—helps guide the project. The members are nominated in the wards and voted on by the patients. Each serves a 2-month term. The council meets twice weekly, with a chaplain serving as moderator, to discuss project activities and ward problems. The council also helps new patients become oriented to the project, and it talks to patients who are disturbing the community.

A recent innovation is a "self-reliance ward," housing some 20 persons, to give patients more privileges and encourage them to accept greater responsibility for themselves and thus to further their movement toward discharge.

In a recent year, 89 patients from this program were able to handle industrial therapy assignments within the hospital, eight were employed outside the hospital, returning at night; five were being trained by the vocational rehabilitation department for outside jobs, and 24 others were being tested and evaluated by the same department; 29 were placed in nursing homes, and one returned; and 43 made lengthy trial visits to their families, for as long as a year, with 21 returning. During the same year, the project took in eight women from a locked security ward. At first they all returned to the locked ward at night, but in the course of time four improved to such an extent that they were transferred permanently to an open ward.

The recreation director supervises this HIP project, and all departments of the hospital cooperate in it. Much of its success is attributed to the skillful way the hospital has been able to use relatively untrained personnel. Pay scales are low in this rural area, the hospital points out, so the recruitment of professional mental health personnel qualified in the traditional, educational sense, is very difficult. Consequently, programs requiring any large number of such personnel are not feasible. However, it is possible to recruit activity therapy personnel whose formal education doesn't extend much beyond high school but whose youthful spirit, fresh outlook, and enthusiasm are valuable assets. On-the-job training includes a 20-hour course in human relations skills.

Another hospital in a successful effort to give its patients more and better attention, assigns them to small groups—about 15 to a group—and delegates the responsibility for treatment to "aide-therapists." These are psychiatric aides working closely with professional members of the staff. This hospital—Osawatomie State, in Kansas (*59*) has also developed a rehabilitation program centered on the social and vocational skills needed by its patients, the majority of whom are farmers, journeymen, housewives, semi-skilled workers, and laborers. Without eliminating the usual arts and crafts, the program includes classes in grooming, table manners, and other social amenities, courses in reading and writing, and training in carpentry, mechanics, electrical work, home decorating, and sewing. Also included are group discussions aimed at developing competence in dealing with problems that commonly arise at home and on the job.

Behavior Modification in an Appalachian Hospital

Like many other State hospitals, the one at Weston, West Virginia, (*60*) in the Appalachians, has found it almost impossible to attract well-trained professionals because of its remoteness and lack of funds. For many years, progress beyond a custodial program was slow. Then in 1965 a HIP grant enabled the hospital to add a number of mental health professionals and to augment chemotherapy with a program of intensive individual and group psychotherapy. This program was used first with acutely disturbed patients and then with selected chronic patients, particularly those with relatives who were interested in having them return to the community. In 4 years, the total number of patients was reduced from 2,200 to 1,750, presumably as the result both of this program and of the growth of outpatient clinics in the area.

The hospital is now worried about those of its patients—the majority—who are unable to socialize effectively or to maintain a satisfactory style of living either in or out of a hospital setting. In many cases they have rural backgrounds. In many cases, too, their behavioral disturbances seem related to a lack of social and educational skills. Since acutely disturbed patients are being treated more and more by outpatient clinics, the hospital thinks that its population will increasingly comprise the chronically ill and those with learning deficits. Accordingly, it is using a HIP grant to introduce a treatment program, based on learning theory, which it believes will be particularly effective with such patients.

The objective is to design an environment in which learning theory principles produce desired behavior and eliminate undesired behavior. Specific goals are to provide better care, increase the likelihood that the patient will leave the hospital and will not have to return, and provide the nursing staff—particularly the aides—with specific behavioral-shaping skills. Achievement of this last goal, the hospital believes, will drastically improve the staff's morale, for it will change the image of a staff worker from "caretaker" to "therapist." Perhaps most important from the standpoint of getting such a program started, the introduction of behavior modification techniques does not require new professional personnel. It can be accomplished through the use of consultants from the State university.

A Behavior Modification Unit is being set up in such a way that appropriate behavior—in particular, activity that indicates the development of self-help and vocational skills and the elimination of psychotic behavior—is immediately rewarded with tokens. The tokens may be used to buy whatever a resident needs or wishes, including meals, items in the store, and such privileges as sleeping late, having a private room, getting individual therapy, watching television, and leaving the grounds. For unacceptable behavior, residents must pay fines—again, in tokens.

Patients stay in the unit no more than 4 months. When they leave, they are either discharged from the hospital or returned to their former place in the hospital. The unit's staff will try to find jobs and homes for discharged patients and will arrange for followup care through community mental health facilities.

Directing the 40-patient unit is a clinical psychologist. However, the unit is operated by the residents themselves under the guidance of "behavioral technicians." These are psychiatric aides who have successfully completed a course of instruction in behavior modification theory and techniques. There are half a dozen such aides. Among others on the staff of 15 are two psychologists, two registered nurses, two therapy aides, and a social worker. Under the plans, volunteers from the community will assist in the resocialization program not only by teaching various skills, such as buying groceries, making change, and maintaining a checking account, but also by taking individual patients to their homes for a day.

The progress of the patients will be compared with that of a matched group of patients from other units of the hospital.

Behavior modification techniques have been successfully used in a number of other psychiatric institutions and, in fact, with individual patients in one of the geographic units at Weston State. They were used there, for example, to induce walking in semiambulatory patients, to encourage apathetic patients to take part in ward activities, and to elicit verbal responses from totally withdrawn patients. In the absence of constant reinforcement, however, only a weak and easily extinguishable response was produced. The experiment pointed to the need for a fully trained staff.

A Transition Ward: Springboard to the Community

Under a HIP project beginning in 1964, the State hospital at Blackfoot, Idaho, (*61*) began moving from an emphasis on custodial care to one on treatment. This hospital serves well over half a million residents of Idaho's 34 southern counties; it has about 300 inpatients. Four years later the hospital organized a "HIP team" charged with helping patients develop attitudes and skills that would fit them for living first on the hospital's transition ward and then in the community. This team comprises a psychologist, who is its director, an education therapist, a recreation therapist, a music therapist, a home economist, and seven licensed practical nurses.

When a patient enters the transition ward, he is assigned his own therapist from the team. This therapist, along with the patient himself, is responsible for charting his progress and making recommendations for staff action. Improved behavior leads to increased responsibility, to increased independence, and finally to discharge.

Each patient on this ward has available the hospital's usual treatment modalities—individual and group psychotherapy, chemotherapy, and activity and work therapy. But he may also participate in dances and special dinners on the ward, go swimming, bowling, and roller-skating off the grounds, attend concerts, movies, football games, and church functions, take part in civic club programs, and go downtown alone. Also open to him is instruction, by team members, in auto driving, money management, home economics, shopping, etiquette, hygiene, yoga, arts and crafts, and a number of other subjects.

Over a recent 27-month period, some 375 patients were involved in the HIP project. Of these, 269 improved sufficiently to be placed in the community, many in Family Care facilities; 63 did not improve and were transferred to other wards and programs; and 42 were on the transition ward at the end of the period. For patients discharged to the community, the average length of stay on this ward had been slightly more than a month. Only 27 of those who had been discharged were back in the hospital.

On the basis of those figures, the efforts to bring as many patients as possible to a transition unit, provide experiences similar to community living experiences, and then place the patients in the community has succeeded. However, the project reports that it has not yet reached another major goal: to make the most effective use of community resources, and develop new ones, so that the former patient will receive whatever services are needed to improve his mental health. An attempt to meet this goal through the use of field workers stationed in the community had little success, partly because the workers did not have adequate information about each patient's needs. Under the plan now being tried, HIP team members themselves become actively involved in fitting patients into the community.

Instead of one transition unit for the entire institution, such units are to be developed throughout the hospital as a means of motivating more patients to work for discharge.

From Hospital to Community in Six Steps

Another means of getting chronic patients out of mental hospitals has been demonstrated by Benton State Hospital, Arkansas, (*62*) which serves one million people in the predominantly rural southern half of the State. There a program known as Small Group Therapy has sent more than 200 patients into the community. About 300 were treated under this program in 4 years. More than half of them have been discharged to live and work in small groups in a city 30 miles from the hospital. The others have been conditionally discharged, to their homes or elsewhere, on the basis of individual plans.

Though all these were chronic patients, mainly schizophrenics, and most had been hospitalized at least 10 years, the readmission rate has been less than 10 percent. The hospital believes that it can not only reduce this readmission rate but also increase the proportion of those discharged, from about 70 percent to perhaps as high as 90 percent.

Patients too old to work and those with severe organic trouble, mental or physical, are not accepted as suitable for treatment in this project. But epileptics and moderately retarded persons, once ruled out, are now accepted. This is mainly because employers have been more tolerant of them than expected.

Persons referred to the project receive a complete physical and psychiatric evaluation, and those with physical conditions that would interfere with rehabilitation are referred to their home ward physicians for treatment. (In the early days, the project found that social and psychological workups usually had not been done in several years; that the nature and severity of the patients' problems had changed; and that physical troubles including tuberculosis, syphillis, cancer, and anemia were prevalent.)

On the ward, a patient is assigned to a group and told about "the system." There are four groups, with an average of 15 members each. The system is a six-step program intended to make him dependent upon the group rather than the hospital. If he conforms to the group's behavioral standards, as set by the staff, he moves through a number of steps towards discharge. At each step the rewards for conforming behavior increase. In Step One he must meet such requirements as getting up on time, dressing suitably, and handling any complaints about group members in group discussions. A patient at this level receives $1 a week for spending money. When he meets the requirements to the satisfaction of this group, it recommends him for Step Two. Additional requirements at this level include satisfactory performance of all work assignments on the ward and elsewhere in the hospital and attendance at all group meetings. Rewards include trips to town, with a staff member, and $2 a week.

It is up to the group to work out problems concerning its members. Staff observations of behavior are made known to a group through notes placed in the group's box, and the observations are discussed at the group's daily meetings. Failure to take appropriate action brings a penalty upon the entire group.

In Step Three the patient must either plan to move into the community with the group or submit an acceptable individual discharge plan. After three consecutive weeks at this level, he is referred to the State's Rehabilitation Service, which has shops on the hospital grounds, and given preliminary job training. He receives $3 a week and may go on trips by himself, after approval by the group and the staff.

When seven or more members reach Step Four, they commute by bus to jobs that the hospital has found for them in Hot Springs, a resort and health community. Employers, who receive a training fee from the Arkansas Rehabilitation Service, agree to accept every member of a group. During this period members may reach Step 5 and be eligible for $5 a week. In Step 6 they move as a group to a furnished house in the community and continue to work as trainees. Their allowance now is $6, and the Rehabilitation Service provides working clothes and a sum to cover rent, groceries, and other essentials. Recently there were a dozen group homes housing about 100 members, who are on the hospital's rolls as outpatients.

The groups work as custodial or kitchen personnel in a resort hotel and a large resort motel; as maintenance crews at a country club; and as kitchen and housekeeping workers and nurses' aides in nursing homes.

Employment contracts are arranged by a nonprofit corporation. It is made up of responsible Hot Springs citizens and professional hospital staff members. The corporation was established to avoid exploitation of the patients and to offer them guidance in money matters. The hospital reports that the corporation has served also to increase the community's acceptance of the project and that both employers and landlords are eager for new groups.

The training period may run for several months or longer, depending on the group's progress. When the employer feels that the patients have learned the jobs, he puts them on the payroll. He pays substandard wages because the patients have been certified as handicapped workers. Since they live in groups, the patients have sufficient means to be self-supporting except for medical care, which is provided by the hospital.

The groups meet for a while every evening to talk about individual and group problems and discuss such matters as home visits and group purchases. One group decided to buy an automatic washing machine instead of using a laundromat. Another began saving for a color TV. Minutes are kept so that the community coordinators from the hospital will know what is going on. The coordinators, a man and a woman, are in touch with the groups and the employers several times a week.

Some of the group members have married and moved away; some have returned home; some have left to work as individuals, but a few of these have continued to live with their groups. The tendency is for the groups to remain fairly intact, and for the older ones to require little attention.

Research done in connection with this HIP project found that many group members whose test scores did not reflect significant personality changes were able, nevertheless, to function satisfactorily in the community. Apparently group interaction provided sufficient support and controls to make such functioning possible.

The situation of this State hospital, which is close to a community offering many jobs of a kind that can sometimes be difficult to fill may be unusual. But a number of other institutions have studied the Arkansas experiment and embarked on similar projects.

A Halfway House in a City

Like the Arkansas institution, a hospital in northern New York State (*63*) serving a six-county district with a large rural population has also turned to a city for help in leading patients toward more independent lives. The hospital is St. Lawrence State, located outside of Ogdensburg, New York, on the St. Lawrence River. It long has had an extensive family care program, providing services for several hundred patients living in homes supervised by hospital personnel. Most of these homes are in rural sections. The hospital has had difficulty finding such homes in the urban areas of its district, particularly Watertown, the largest city, some 60 miles away. And cities, in the hospital's view, have social, cultural, and educational resources that can help speed a patient's rehabilitation; very important, too, they offer employment.

To help patients take advantage of these resources, the hospital established a halfway house in Watertown late in 1968. It holds a dozen patients and is limited to women. The hospital has found that women have more difficulty resuming independent living than men. A resident psychiatric social worker directs Halfway House; a psychiatrist and a psychologist are available for consultation; and two "colony supervisors," with long experience as staff attendants at the hospital, take parental roles and work with the patients on housekeeping and maintenance duties. Patients and staff together establish regulations. Patients are encouraged to attend a social club, make friends in the community, and become aware of others' needs as well as their own. Cooperating with Halfway House are a sheltered workshop, the State divisions of vocational rehabilitation and employment, educational institutions, and other community-based agencies.

Twenty-one patients resided in the house during the second year of this HIP-financed project. Seven of these were able to move into the community as independent, self-sustaining members; two moved into family care homes; two had to be returned to the hospital for more intensive psychiatric treatment than can be offered at the house. The remaining 10 patients were at various stages of readiness for the step to independent living.

With Student Help, a 7-Day Week

A few years ago a hospital serving 16 counties in Southern Illinois noted that its treatment program, in spite of many improvements, was limited essentially to a 5-day, 40-hour week. (*78*) As an important step toward reaching its ultimate goal of a 7-day program, the hospital proposed to hire a number of college students. Through lectures, they would be trained and supervised as activity therapists, and used to provide an extensive activity-therapy program evenings and weekends. Through an HIP grant, this proposal was put into effect. The students work full-time during the summer, when the bulk of their training takes place, and part-time during the school year. Recently 35 student therapists were averaging 21 hours a week.

The outcome is evidence that college students can be an important personnel resource even for hospitals distant from large cities. The number of patients engaged in activity therapy has doubled. Other gains include the establishment, at patients' request, of groups with special interests such as cards, chess, physical fitness, nature, library, social, current events, music appreciation, and a staff-patient band, and development of other programs to meet the needs of older people and adolescents. The hospital has also used students to initiate activity programs for people in nursing and sheltered-care homes throughout its area.

Counted also as important payoffs are (1) the opportunity to recruit full-time staff members from the students upon graduation and (2) changes in the attitudes of some nursing service staff members toward the possibility of programs during what had been "custodial hours" and toward the ability of college students to conduct them.

The students in the project, which the State takes over when NIMH support ends, have come from Southern Illinois University and Southeast Missouri State College. To recruit them, the hospital got in touch with the heads of the departments of art, music, sociology, community development, psychology, home economics, education, and health and physical education.

In a somewhat similar project, a State hospital serving an isolated area in Western Kansas used HIP funds to recruit and train high school, college, and postgraduate students for work in the institution, mainly in the summer but in some cases year around. (*79*) Over a 3-year period, 80 young men and women participated in the program, thus helping the hospital provide better care for its patients. Eight of the students joined the full-time staff. Indirect benefits included an increased awareness, in schools and communities, of mental health problems and programs.

Rural Communities as a Haven for Patients

Up to this point, the chapter has dealt with programs for improving the ability of the State hospital to serve patients from rural areas—along with, of course, the other patients the hospital may have. The chapter now looks at a project for improving the ability of rural areas to serve the State hospital. The project seeks to establish partnerships between rural towns and a State hospital to the end that men and women who have been hospitalized for years may live again in a community. It is supported in part by NIMH, through a special project grant.

The enterprise is under the auspices of the Missouri Institute of Psychiatry, which is a research and teaching hospital of the University of Missouri's Medical School. (*64*) The Institute is on the grounds of the St. Louis State Hospital. Two small towns in Eastern Missouri have become involved as foster communities.

What sets this project apart from other similar programs is its emphasis on foster communities rather than on foster homes. Staff members point out that in foster home programs, the home frequently becomes simply a custodial place for patients not yet old enough for a nursing home; the patient is isolated from the community, at least partly because the community still views mental patients with distrust and fear. In the Missouri experiment, however, the State hospital patient who lives in somebody's home is not so much a boarder as a member of the family; and whether he lives with a family or in his own apartment, he has community ties. He is an active member of at least one organization, usually a church, and, like anyone else, he goes downtown to shop, get a soda or a beer, attend the movies, or just look around.

The patients selected for the project usually have a diagnosis of schizophrenia and, like most other chronic patients, are oriented toward the hospital rather than the community. Of the first 33, the average length of hospitalization was 10 years and the average age, 45. Some patients had been hospitalized for as long as 30 years; most were regarded as hard to treat and hard to place.

The patients are prepared for community life through a resocialization program at the hospital, first in a special ward and then in apartments on the grounds. They learn not only that they can and must take care of themselves but also that social relationships are both gratifying and essential to survival. Families that take patients into their homes are paid $120 a month, which is less than the cost of hospitalization; and patients without income are paid an allowance to cover personal needs.

The patients in the program have been accepted by the rural communities first as lunch or dinner guests, then for a weekend, and finally, a number of them, as residents. Some live with townspeople in their homes; others have their own apartments; and a few have found work. Almost all the patients may need some guidance and support indefinitely, but the project has demonstrated that sufficient guidance and support can be obtained in a more life-fulfilling atmosphere than that of a holding institution.

The foster communities were chosen after extensive surveys to find small towns that were no more than 60 or 70 miles from the hospital, had a record of progress and civic pride, and were economically strong and independent, so that workers did not have to commute to St. Louis and so that new residents would not be resented as competitors. New Haven, a town of 1,500 about 65 miles west of the city, was selected as a likely prospect early in 1968. Talks between staff members and several town leaders were followed by presentations to community organizations and by a series of citizens' meetings as well as interviews with community members. In January 1969, the New Haven Foster Community Project, Inc., was set up as a nonprofit body to guarantee citizen representation in planning. During the following year, committees of this organization arranged more than 200 visits to New Haven, most of them for weekends, by 25 patients. A dozen patients were living in New Haven in 1971 and arrangements for more were being made.

In 1971, Troy agreed to become the second foster community. It is a town of 2,500 people, about 60 miles northwest of St. Louis. This time preparatory arrangements required only a few months instead of a year, mainly because New Haven people bore witness to Troy of their favorable experience. A survey conducted in New Haven had shown that a large majority of the townspeople considered the program highly worthwhile; no one thought it of little or no value; and 35 percent had taken some part in it.

The project's staff has included its director, who is a psychiatrist; two social workers; a community health nurse; a rehabilitation therapist, who works principally in the resocialization program; and a community field worker. In 1971 the part-time position of community mental health technician was created for New Haven and filled by a young mother long active in the project. This new position meets the need for someone to act as liaison between the community and the hospital, to follow up patients, and to help place additional patients. Creation of the new post substantially reduces the need for community visits by professional members of the staff.

From its experience to date, the staff draws a number of tentative conclusions, among them:

1. Foster homes of the type desired—limiting themselves to one or two patients and treating them virtually as family members—are difficult to recruit. This is true even in a town such as New Haven where people have become favorably disposed toward mental patients. No more than a dozen families have accepted patients for extended periods. However, 50 families have had patients for weekends, and perhaps another 50 have participated in other ways, such as helping patients furnish their apartments.

2. The use of apartments supervised by community members is an acceptable alternative to foster homes and in some cases may speed the patients' steps toward greater independence.

3. Women are much easier to place in foster homes than men. In part this seems to stem from the idea that a man should have a job. Of the five male patients who were weekend guests in New Haven, four were clearly not ready to work, and townspeople advised against trying to find homes for them. The fifth went to

live with a man separated from his wife, got a full-time job, and has since been discharged to a relative in another State. The project found a good boarding home in St. Louis for the other four, two of whom are now working.

4. The number of mental patients a foster community will accept is probably equal to 1 percent of its population, or perhaps a little higher. To place a larger number of patients in a small rural community is to run the risk of creating—at least in some residents' minds—a colony of mental patients.

5. Public transportation is desirable, for patients should not have to depend entirely upon friends with a car. New Haven has no public transportation; Troy has taxis.

Under discussion are:

- Ways of bringing mental health services to the foster communities, in partial payment for the communities' services to the hospital.
- Training young mental health personnel by assigning them to develop a third foster community near St. Louis. At the end of training, they would develop foster communities for hospitals in other parts of the State.

Special Attention to Older People

One of the most difficult and most often neglected problems of a mental institution is posed by those patients with a chronic mental disorder who are old or infirm or both. Lack of adequate rehabilitative measures prolongs the hospitalization of these patients and, as a result, complicates their problems. Since their basic needs are met by aides who function for the most part in a custodial way, their bodies become less and less flexible, and their minds and social abilities diminish. Such patients can reach the point where they resent and even resist efforts to change them.

However, projects supported by HIP grants have demonstrated over and over that when elderly patients are subjected to modern treatment programs, a significant proportion of them can be rehabilitated and leave the institution. The results have proved beneficial to the patients and their families and have raised the sights of those hospital personnel who have become used to dealing with old people as custody cases.

A Therapeutic Community Unit

A Maryland hospital, 60 percent of whose patients were 65 years old or older, set up what it called Operation ENCORE—the Effect of New Concepts of Rehabilitating the Elderly. (*65*) The effect turned out to be highly encouraging. Over a period of 18 months, approximately 100 patients received special treatment in an HIP-supported unit, which accommodates 24 at a time, and more than half of them left the hospital. The patients' average age was 79, and their average length of hospitalization almost 2 years. They stayed on the HIP unit about 3 months. Of those released, eight had to return.

What the hospital—Eastern Shore State, at Cambridge, Maryland—developed in its special unit was a therapeutic community with strong relationships between patients and the treatment team. The team included a psychiatrist, nursing personnel, social workers, and rehabilitation workers. The project aroused so much interest that the hospital created a day-program for older people. Also, other parts of the institution began using the project's ideas.

"Ambulatory elderly patients," this hospital administration has observed, "can respond almost as readily as younger patients on psychiatric admission wards. Rejection of those patients over 65 by the psychiatrist and the admission units, augmented by relegation to custodial, inactive units, where levels of expectation are minimal, invariably leads to the confirmation that senility is chronically progressive and incurable."

A Program That Includes People in Wheelchairs or Bed

Kankakee State Hospital, at Kankakee, Illinois, (*66*) whose 1,500 patients include a large number from rural sections, has demonstrated that a rehabilitation program can benefit even some older people who are bedridden. In its rehabilitation center, established with aid from HIP, emphasis at the start is on the restoration of physical functioning to as high a level as possible. At the same time, recreational and occupational programs try to increase a patient's interest in himself and in others, develop self-confidence, and arouse interest in life outside the hospital. A social worker and a public health nurse explore the possibilities for a return to his family or to some type of foster care.

During its first 2 years, the project treated approximately 120 patients. On the average they were 60 years old and had been in the hospital 9 years. Seven were in bed and 61 in wheelchairs; seven used a walker or crutch. In terms of mental involvement, the three principal categories, each with about 25 patients, were schizophrenia, chronic brain syndrome with psychosis, and chronic brain syndrome without psychosis.

Almost three-fourths of these patients were discharged to the community. Of the others, at the end of 2 years, 20 were in the process of being discharged or were undergoing further rehabilitation, and 14, for lack of progress, had been transferred to other wards. Of those discharged, only seven were known to have been readmitted to a hospital. All the bed patients had advanced to the wheelchair stage or beyond, and all but one of the wheelchair patients had advanced to the walker stage or beyond. The average length of time on the program before discharge was about 4½ months.

Plans call for modifying the program by (1) accepting some patients whose prospects for discharge are small but whose health and happiness can be enhanced by rehabilitative measures, (2) providing partial hospitalization to ease the return to the community of some of the patients and to serve as an alternative to the readmission of certain former patients, and (3) providing more intensive services, including the use of a sheltered workshop off the grounds, for patients with markedly underdeveloped social and vocational skills.

Before opening the center, the hospital engaged a consultant in physical medicine and rehabilitation to organize and guide the program, sent a physician and two rehabilitation nurses for additional training in rehabilitation medicine and techniques, and hired a registered physical therapist. Other members of the project staff include a clinical psychologist, a social worker, an occupational therapy aide, two former nurse's aides who were trained on the job to become physical therapy aides, and 16 psychiatric aides.

Meeting a Variety of Needs

As State hospitals, with help from NIMH, give new attention to their elderly patients, they often find it necessary to divide them into groups needing different kinds of services. The geriatric unit of the Mental Health Institute at Independence, Iowa, (*67*) for example, which receives all patients over 65, assigns them to one of two groups. One group comprises persons who seem to have treatable and reversible psychiatric reactions, even if some organic pathology exists. The hospital finds that in many cases the basic disorder is of a general medical character—such as cardiac decompensation, infection, and even such simple matters as temporary dehydration during hot weather—not recognized initially as the factor precipitating the mental trouble. Patients with psychologically determined pathology also go into this group, as do those who come to the hospital depressed because of some environmental stress, such as the loss of a life partner.

The second group comprises severely, organically deteriorated patients judged to be unable to benefit from any kind of intensive psychiatric treatment. The hospital believes that such patients are generally handled best in nursing homes or other custodial homes. However, some patients in this group did show sufficient improvements to be transferred to the intensive treatment unit set up for the patients in group one.

The intensive treatment unit was decorated to make it more homelike. Staff members at every level were chosen for their empathy with elderly patients. Psychiatric aides were taught that in most mental disorders, particularly among the elderly, there are parts of the patient's original personality that remain relatively intact. In remotivation sessions—group discussions of everyday matters—the aides concentrated on the intact features. Through arts and crafts, games, ward government, physiotherapy, work assignments, and other activities, every effort was made to give each patient a sense of usefulness and accomplishment.

Two years after the introduction of this HIP program, the average length of stay for geriatric patients had dropped from 122 days to 75. Approximately 325 geriatric patients had been admitted during this period, and 350 discharged, about a third of them to their own homes.

Another State hospital, in Danville, Kentucky, (*68*) concluded that about half of its elderly patients would have to remain hospitalized but that the rest should be able, after treatment, to go back to their homes or to some kind of sheltered care in the community. This finding followed 3 years of experience with a HIP project to improve the hospital's geriatrics unit. The number of patients in that unit dropped from 375 to 250 during those years, largely because of better treatment and placement programs. In addition to a physical restoration program, the grant made possible an "activities for daily living" program, in which, for example, patients are taught to work in the kitchen even though partly disabled, and a functional occupational therapy program which engages many patients in gardening, sewing, ceramics, and woodworking. New facilities in the Geriatrics Unit include a beauty shop, a library, and a chapel.

Northern State hospital, at Sedro Wooley, Washington (*69*) is developing what it describes as the spectrum approach to meeting the needs of older people. This calls for a range of projects, including the establishment of a Geriatric Evaluation Center, wider efforts to place in the community those geriatric patients with only a slight disability, and special attention to geriatric patients with irreversible disabilities—in an attempt to help them master the tasks of daily living and lead a more satisfying life whether or not they must stay in the hospital.

Under this program a number of specific advances have been made, among them:

- Institution of weekly meetings at which staff members, of all levels, review the treatment and progress of patients.
- Assignment of new patients having relatively mild dif-

ficulties to an open ward. These patients no longer eat on the ward but with hospital staff in the main dining room.

- Assignment of patients as they move through the center to the same doctors that treated them in the admissions area, not new ones.
- Development of color-coding systems to mark the location of bathrooms and other facilities; introduction of orientation tours for patients about to be transferred to a different ward; encouragement of patients to participate in ward government meetings.
- Provision of staff for aftercare services and for consultation in the community.

At least partly as a result of these and other improvements, the hospital reports an increase in the number of long-term, severely disabled patients discharged to nursing homes or other community facilities. Also reported is a reduction in the length of time—from an average of 4 to 3 months—that patients spend in this program before being discharged directly to the community.

Special Attention to Young People

Thanks to the Hospital Improvement Program, a number of State hospitals serving rural communities have been able for the first time to give special attention to emotionally disturbed children and adolescents. Previously it was customary to house these patients on wards with adults. Special provisions for care and treatment have become more important than ever because the population of young people in State hospitals—in sad contrast to the total population in these hospitals—has been rising.

Units for Children and Adolescents

In Cherokee, Iowa, a State Hospital serving a large and predominantly rural area used HIP funds to establish a 30-bed Children's Unit for patients from 6 to 16. (*70*) The unit includes individual bedrooms for most of the children, a school wing with six classrooms, an occupational therapy room, a gymnasium and other facilities. In addition to the children who live at the hospital, the program cares for a number of others—including disturbed children under 6—as outpatients. It also provides day care for a few children who live close enough to go home at night. A few of the inpatients go to a public school. The hospital found it desirable to provide individual and group therapy for parents as well as children. On the ward, in the Unit's school, and in planned activities, the program uses behavior modification techniques.

About 120 children became inpatients during a 3-year period, and 100 of these were discharged after an average stay of 6.5 months. About a sixth of these were placed in other institutions and another sixth, in foster homes; two-thirds went back to their own homes.

The project's school and group therapy programs were eventually extended to some of the adolescent patients, over 16, living in the adult building.

Another Iowa State hospital—the Mental Health Institute at Mt. Pleasant—found that for the most effective operation its new HIP-supported Children's Unit would have to set the age limit at 12. (*71*) Later, responding to demands for more services for troubled teenagers, the hospital began paying the unit's personnel from other funds and used the grant money to staff a separate unit for adolescents.

In treatment, some attempt is made to help the adolescent become aware of the origins of his inappropriate behavior, but the major emphasis is on the here and now. The aim is to help the young person express his emotions appropriately, to demonstrate that he can get his message and his feelings across without resorting to behavior that brings negative results. The unit has found that its adolescents, many of whom have been referred by the courts, typically have very few behavioral approaches and need help in developing additional and more appropriate ones. Individual responsibility—for keeping rooms presentable, for good grooming, and for acceptable social behavior—is emphasized. Whenever possible, behavior is rewarded. Each person on the unit's nursing staff is assigned a specific patient so that the adolescent can feel he has someone to turn to and so that the unit can better judge his needs.

The hospital's school program, in which the adolescents participate, includes the usual academic courses and a wide variety of others. Among them, are homemaking, metal work, and family-life education.

Admissions to the adolescents' and the children's units have been increasing, particularly those of patients from 13 through 18, who have been coming in at an average rate of 10 a month. As a result the hospital is establishing a Screening, Evaluation, and Short-Term Treatment Center. Its aim is to (1) provide rapid, intensive service at the crisis period or on admission; (2) increase the number of patients seen without increasing daily inresident population; (3) treat inpatients more appropriately and effectively; (4) reduce the length of stay for many patients; and (5) improve the continuity of care between community and hospital.

Programs of Education

Like many other mental institutions, Cherry Hospital, at Goldsboro, N.C., used to house children and adolescents on the same wards as adults and treat them in the program for adults. Most of them were referred by correctional institutions, training centers, and community agencies. The hospital acknowledged the situation to be "heartbreaking" but had no funds to change it.

With HIP money, the hospital remodelled two wards to provide beds for 30 children and adolescents, and established an educational as well as a treatment program. (*72*) Recently, the hospital has been admitting children to this unit at the rate of 60 a year and discharging them at almost the same rate. They range in age from 6 to 18 years. The average length of hospitalization among new admissions has been running 4 months. Long-term patients include autistic children, who are learning to tolerate group activities and to accept classroom instruction for short periods.

Since most of the children have been economically, culturally, and educationally deprived, the unit's school and recreational programs make special efforts to provide enriching activities. A day hospital program has been opened for troubled adolescents who live near enough to go home at night. They attend the unit's school and participate in the recreational program.

A grant to Lakin State Hospital, Lakin, W.Va., enabled it to open an intensive treatment program for emotionally disturbed children from 7 through 16, the first such program in the State. (*73*) Activities have included regular and special school classes, Boy Scout and Girl Scout programs, camping trips, play production, ceramics, the painting of murals to brighten bedrooms and halls, and the use of a new children's library. At the end of a 3-year period, 24 children out of 69 admitted had been discharged as improved and 11 as unimproved. Another 22 were improved and out on trial visits.

Going to School in Town

In Northwestern Pennsylvania, Warren State Hospital established an adolescent unit in 1957 and doubled its size to 40 beds with the help of a grant in 1965. (*74*) The grant made it possible to replace old toilet facilities with modern baths and showers, brighten the dormitories with new spreads and individual wardrobes, buy athletic supplies, home economic equipment, and record players. They also engaged additional staff members—two social workers, a nurse, and seven psychiatric aides.

Arrangements were made with the local school system so that more than half the hospitalized youngsters could attend the regular schools, at least part time. Transportation was provided by school bus. (About 65 percent of the patients had been diagnosed as schizophrenic, and about 20 percent as mentally retarded.) One patient became a star on the local high school track team; another, concert master of the high school orchestra. Several have been prominent in school choral groups, and several others have won awards in school and community art contests.

The grant also made it possible for a number of indigent youngsters to buy clothes appropriate for attending school and other community events, to pay the fees for such events, and to get to and from them. Patients attend community concerts, athletic contests, school dances and plays, and swimming classes, and go on camping trips with Boy Scouts and Girl Scouts. Volunteers arrange for instruction in art, dancing, social graces, and cosmetology. Though the patients have not been free of unpleasant experiences in the community schools, prejudice is reported to be far less than might have been expected.

Patients too disturbed to leave the hospital attend special classes provided by the Pennsylvania Department of Public Instruction. Each class is limited to six children.

The Adolescent Unit is designed for long-term residential care. In a recent 3-year period, the average patient stay decreased from 26 months to 13. The discharge rate has ranged between 90 and 95 percent.

The hospital reports a decided increase in applications for the admission of adolescents who—as shown by preadmission screening—are not appropriate patients for State hospital care. Consequently it has increased its consultation services to families and agencies needing information about programs able to help the adolescent who is emotionally troubled but not actually psychotic.

A Project for Alcoholics

In West Virginia a HIP grant enabled the State hospital at Spencer to staff a 20-bed unit for the treatment of alcoholism. *(80)* Alcoholics throughout the State were considered for admission provided they were not psychotic, had undamaged brains, and were sufficiently intelligent to participate in a therapeutic program built around group process. Individual psychotherapy, casework, recreational and occupational therapy, and vocational rehabilitation services were offered during the 6-week program according to patients' needs. Alcoholics Anonymous participated.

Of the first 400 patients admitted to the unit, 60 percent had been previously treated for alcoholism. A followup of 300 after they had been discharged a year or more found more than half of them improved, including a fourth who were totally abstinent. About a third were not improved. There was no information on the others.

The staff found the following characteristics to be universal in alcoholics: (1) anger approaching the rage level; (2) depression, which was generally well-covered but marked the alcoholic as a deeply sad individual; (3) low self-esteem, though it was denied; and (4) continuous testing for rejection.

Under a technique developed to improve the therapeutic process, the group was permitted to direct questions at any member, who had to answer truthfully or else refuse to answer. If the group felt that he was rationalizing or attempting to evade the issue, the members might challenge him. The discussions were permitted to be as heated as the group liked. When this technique was used, feelings of hostility were less repressed in the regular group therapy meetings, and therapists spent considerably less time in dealing with patients' anxieties.

Aiding the "Criminally Insane"

The revolution in mental hospital care made possible by the Institute's program of grants, coupled with help in planning, has extended to those maximum security units and hospitals generally known as institutions for the criminally insane. Their patients come from both country and city. Following are three examples of HIP at work in such institutions.

Texas: Patients Become People

The maximum security unit at Rusk State Hospital, in Eastern Texas, must accept any male committed by any criminal district court in the entire State. (75) In the early part of this century, the hospital itself was a prison unit, and when the 354-bed security unit was opened in 1954, it was staffed by attendants selected for the most part because of their brawn and bravery. Experience in penal institutions was a good recommendation. The patients' activity was sitting on benches or lying on the floor, in the halls; the dormitories were locked until evening. The rules called for all clothing to be left in the halls at night, so it could be inspected, and for handcuffs to be placed on patients outside of the building. Patients were limited to one bath and two shaves a week.

In 1966 the hospital administration, backed by HIP money for additional personnel and facilities, instituted a major improvement program. It was based on the principle that people in the maximum security unit merited care and treatment on the same level as other mentally ill people. Advances since then include:

- The team approach in treatment: frequent conferences by psychiatrists, psychologists, social workers, and other staff members to share information and coordinate activities.
- Behavior therapy. Patients get points for taking part in therapeutic activities and also for working. The points buy privileges. Depending on such factors as behavior, attitude, participation in activities, and security risk, the patients also move from one of the unit's seven levels to another. Each step up brings additional privileges.

- Patient government, operating through ward councils and a unit council. Patients are free to discuss any problem and to recommend action.
- An educational program that includes (a) classes ranging from elementary to high school level, in which more than a third of the patients are enrolled, (b) extension courses for college credit; (c) a course, offered to both staff and patients, to train "remotivators" to work with withdrawn and inactive patients.
- An occupational therapy program that includes both a well-equipped shop and activities for patients too disturbed to use the shop.
- A variety of recreational activities, including organized competitive sports. For the first time, many of the patients are engaging in a team activity.

Among other improvements are unlimited mail privileges, libraries, a canteen, salt and pepper shakers on the table at meal times, permission to keep personal items on the wards, and permission to meet visitors in the open instead of being separated from them by a steel screen.

Behavior problems are diminishing, the hospital reports, because of a newly recognized need for group acceptance and because of the improved attitudes of attendants as well as of patients. The discharge rate for patients committed by District Courts has improved, and a number of patients have been transferred to the regular hospital.

Illinois: Recreation Pays Off

The Illinois Security Hospital, at Chester, used an HIP grant to institute a full-scale recreation program for its patients. (*76*) These are men from every section of the State who have been arrested in connection with a crime but found incompetent to stand trial or whose behavior at other State hospitals has indicated they should be closely supervis[illegible] On a recent date, about half the 260 patients came from areas other than Chicago. Of those committed by the courts, more than half had been charged with murder or attempted murder; of the others, more than half had been transferred for assaultive behavior, murder, or attempted murder.

The HIP money went to employ a staff—including a recreation worker, six activity therapists, and two activity program aides—and to buy supplies. Activities range from individual patient projects in arts and crafts to interunit competition in softball and basketball. Pool, ping pong, exercise classes, movies, and band and chorus are included.

The resistance of security personnel to "playing with" people who are "dangerous criminals" has gradually been replaced by the attitude that it may be desirable to relate to patients with some degree of feeling for them. Also, as the result of activities conducted by the recreation staff, the hospital has been won over to the idea that not all its patients are "dangerously insane." So a number of patients—the proportion rose from zero the first year to 65 percent the third—have been permitted to participate in off-grounds activities. These have included picnics, fishing trips, nearby fairs and parades, and 150-mile roundtrips to St. Louis for major league ball games.

To this recreation program is attributed a large share of the credit for:

- A more precipitous decline in the length of hospitalization, which dropped from about 6.75 years the first year to about 4 the third.
- Fewer injuries to hospital employees, a decline attributed to the opportunity given patients to release energies in recreational activities.
- A clearly less hostile attitude by the majority of patients.

Pennsylvania: Force Gives Way to Counseling

Farview State Hospital at Waymart, in Northeastern Pennsylvania, is trying a different approach—employment of mental hospital counselors to work directly with patients on the ward. (77) The counselors are college graduates trained on the job. Until this HIP project got underway in 1969, the only personnel working at the ward level were the psychiatric security aides, formerly known as guard attendants. Sixty percent of them had less than a high school education; 20 percent had not gone beyond eighth grade. Though the hospital provided a full range of therapeutic services, it did not have anyone on the wards equipped to give individual counseling on such problems as worries about family and money, adjustment difficulties, feelings of anxiety and depression, and the urge to act out. Force was used as a way of control.

This institution receives male patients from the entire State who have been convicted of crimes or found to have criminal tendencies. They number about 1,250 and range in age from 16 years up.

The hospital hired nine ward counselors and put them to work at once, under the supervision of a social worker and a psychologist. There was a 6-month orientation period, but it was primarily a learning-by-doing experience, plus discussions on the dynamics of mental illness and on methods of bringing about changes in patients. Later, responding to the counselors' requests, the psychology and social service departments helped the new employees acquire more specific diagnostic and treatment skills. Generally the counseling has gone hand-in-hand with tangible services, such as taking care of requests for ward changes and helping with disability investigations. The counselors have permission "to stick your nose in anywhere."

During the project's first year, the number of fights among patients, attacks on security personnel, and other acting-out incidents decreased noticeably. With counselors available, the hospital explains, patients could talk out fears and anxieties and thus had less need for acting them out. Also, the counselors' presence put a brake on any sadistic guard who might have liked to encourage fighting among patients or to have handled a patient's anxiety with force.

Disagreements between the counselors and the psychiatric security aides, who felt threatened, were frequent in the beginning. But the aides came to recognize that the counselors were not out to get power. In fact, many of the aides themselves became interested in doing more for the patient than just guarding him.

Through the counselors, a semiannual, clinically-oriented report on all patients, some of whom had not been evaluated for years, was instituted. Patients improved under the new program, the hospital reports. A considerable number have been moved out. Some were returned to the courts for disposition of the charges against them, some to penitentiaries to serve their remaining sentences, and some to noncriminal institutions.

Perhaps most important for their lasting effectiveness, the counselors have been accepted as part of the professional team.

Grouping Patients by Geographic Units

The most common and probably the most effective innovation in mental hospital administration during the last decade has been the establishment in one form or another of the geographic unit system. HIP grants have enabled a number of State hospitals with rural patients to take advantage of this development.

Under the unit system, patients are grouped according to geographic residence instead of by such traditional means as diagnosis, behavior, or length of time in the hospital. Since patients on a certain ward or group of wards are from the same community, the system lends itself to establishment of treatment teams with responsibility for patient care both in and out of the hospital.

The unit system known as the Clarinda plan, because it was developed at the State hospital at Clarinda, Iowa, won an American Psychiatric Award in 1960. Its developer is a psychiatric nurse who became coordinator of continued care at a community mental health center in Vermont, described in Chapter V. In a recent interview, he discussed its start. He recalled that "Everybody was saying: 'I have a hundred beds, I have a hundred patients—what can I do?' Nobody was doing anything to the program—just shifting patients and shifting personnel, and arguing this and that. . . . Well, our game was different. Regardless of whether the patient was young or old or chronic or acute or male or female or continent or incontinent or pretty or ugly or whatever, that patient came from a catchment area. And the team cannot pass that patient back to the superintendent or shift that patient to another ward. That team has a catchment area, and the problems of the people from that area are the team's problems. And believe me, solutions began popping up, because when you cannot do anything to avoid a problem, you are going to start facing it. And when you start facing things, someone somehow is going to come up with a better approach. Competition begins, and this is the element that was so wonderful; we decentralized and then for the first time competition began."

In one State hospital testing this concept, patients from the same county were housed and treated together. (*81*) They also participated, with nursing personnel, in group discussions that emphasized planning by the patient himself for his early release and for assuming the responsibilities that would be his when he left the hospital. A significantly greater proportion of the patients thus treated were released from the hospital (87 percent as compared to 75 percent for patients in a control group), and a significantly smaller proportion had to return (not quite 20 percent as against more than 30 percent).

Unit programs also tended to bring staff and community closer together and to facilitate relationships between mental health workers in the hospital and people in the catchment area who could help the patient readjust to the community, and vice versa.

2. Grants for Hospital Staff Development (HSD)

Since 1964 the HSD program has provided financial help and professional advice to improve the quality of patient care in mental hospitals through the inservice training of hospital personnel. Unlike the training programs discussed in Chapter VII, it aims to increase the competence of people who are already on the job in State hospitals. HSD is essential because the views held by many of these staff members about mental illness and its treatment have been shaped by experience in hospitals that were primarily custodial or holding institutions. Where such views prevail, the effect of hospitalization is often worse than the trouble that sends a person to the hospital.

The HSD program was directed initially at those personnel who were involved in direct patient care, particularly attendants and aides. Because staff members at all levels were found to need information on the new concepts of mental illness and the new approaches to treatment, the program was expanded to include everyone with responsibilities for patient care, including those who supervised such personnel. Instructors at first were drawn from the ranks of psychiatric nurses and senior aides. They were given additional training themselves, plus assistance in the form of consultation. Later, as the HSD projects extended their coverage, instructors from other divisions of the hospital were needed. Hence, the hospitals in this program have been urged to form training committees composed of representatives from each department, professional or nonprofessional. The goals have been the improvement not only of patient care itself but also of such related concerns as staff morale, communication between staff and patients, communication among staff members, and the rates of staff absenteeism and turnover.

The staff development program has been especially beneficial to public mental hospitals serving large rural areas, for most such hospitals are distant from urban centers and therefore have greater than usual difficulty in attracting and holding a sufficient number of personnel with sufficient training. One hospital in a rural area of Missouri (*82*) expressed its difficulties as follows:

"Most of the nursing supervisors are relatively permanent local people who either grew up in this vicinity or are members of families who have settled here. Most of them have had very little psychiatric training. We cannot realistically hope to recruit psychiatrically trained nursing supervisors from outside the area. We must depend on our existing supervisors for continuing on-the-job training of ward personnel as part of the supervisor's regular job." And that has meant training the trainers with the help of an HSD grant.

As with HIP, the specific amount of the award for each HSD project approved by the National Advisory Mental Health Council will be determined by the Regional Health Director or his designee. In 1972 about 180 institutions had such grants. The next year the number fell to 114. This represents about 40 percent of all the hospitals that are part of the States' mental health systems. The 1973 grants totaled approximately $2,600,000.

General Training Goals

A State hospital serving many rural patients in Idaho (*89*) comments as follows on a problem common to many such institutions:

"The chronic patient is not the only person stagnated in the hospital. Often the hospital aide falls into this category. However, his 'chronic' condition appears in the form of helplessness and apathy in not knowing what to do for the patient. Many of our aides feel inadequately trained to understand the patient's needs—they question that they have anything to contribute to the patient's well-being." The answer lay in further training for the aides, to increase both their competence and their confidence, and for other team members, to promote acceptance of the aide as a member of the treatment team.

The training objective of another such hospital, in Minnesota, (*83*) is "to broaden the therapeutic base among hospital personnel regardless of discipline, profession, or work assignment." And the program's emphasis is on "helping participants learn to understand patients as individuals with problems in living rather than as disease entities. . . ." This hospital points out that some patients' complaints "center around problems of self-esteem, trust, identity, and basic acceptance" and that such patients need "many hours of close human relationships." The training program aims to help the trainee "become more aware and acceptant of himself and consequently more confident in his ability to enter into close human relationships."

A hospital in the State of Washington (*84*) believes that "removing the staff member from the constraints of the hierarchical hospital structure to a neutral environment for an intensive learning experience at spaced intervals is invaluable. Staff then begin to see each other as people and not as psychiatrists, attendants, housekeepers, or accountants. As a result they are able to function with other staff in a more productive manner to tackle the problems of improving patient care. They also relate better to patients and see them as human beings with all the needs they present. Therapeutic relationships are greatly improved when staff are able to utilize their newly gained skills in patient care."

A training program at a North Carolina (*85*) hospital aims not only at increasing the attendant's skills but also at assuring him that he has the opportunity and is expected to assume the therapeutic role his new skills open up.

The State hospital at Larned, Kansas, (*86*) some distance from centers of population, has based its efforts in staff development on the following assumptions and principles:

1. All human behavior can be modified.
2. Every interpersonal transaction is a learning opportunity and therefore potentially therapeutic.
3. The patient should be regarded as an active participant in his own treatment in contrast to the passive-dependent "sick role."
4. Every hospital employee and patient is of potential therapeutic and training value.
5. Further inservice training will provide new trainers, the training system thus serving to renew itself.
6. Responsibility for decisions should be shifted downward in the hierarchy to the point where decisions will be implemented.
7. Treatment based on human relationships must be devised and carried out by the people who take part in these therapeutic transactions.
8. Social behavior is complex. Therefore, the institution must create an environment which will elicit and reward complex social behavior such as learning new skills, roles, and attitudes; learning to learn; and coping with flux, hardship, and frustration.
9. Each section team is responsible for developing a therapeutic milieu and continually revising it in the light of feedback and evaluation.

The overriding concern of instruction, the hospital reports, is to encourage shared responsibility and involvement. "All workers will be encouraged to become 'model-builders' or 'concept-builders' so that they get practice and assistance at seeing the essential aspects of a situation. . . ." The program emphasizes the development of frontline supervisors as trainers. Larned believes that these not only do a better job of training but also provide a continuing supervision that facilitates the application of new learning to work performance.

Improving Relations With the Community

In addition to raising the competence of staff members to handle their duties within the hospital, HSD grants have been used in a variety of ways to improve staff understanding of the community in which the patient developed his illness and to which he will return. Such understanding, and the services following from it, provides the best hope of reducing the number of both first admissions and readmissions. In the State of Washington, (*84*) for instance, a mental hospital used HSD funds to help train staff members to go out and provide consultative services in the communities using the hospital. Thus barriers created by distance and travel time were overcome.

In a hospital in Alaska, (*87*) the HSD project is designed to help the staff understand the culture of the remote villages from which many of the patients come. A special team, visiting these villages with camera and recording equipment, gathers information about the environment to which the patient will return. The team tries to learn about the family's understanding of mental illness and its attitude toward the patient, the economy of the village, and other pertinent questions. This information becomes part of the training course for hospital staff members.

In a Kentucky hospital, (*88*) grant funds are used to strengthen the working relationship between the hospital and the mental health center located in the same area as that served by the hospital. The objective is to improve continuity of care and thus enable the patient to sustain himself in the community, with the help of the mental health center, when he is discharged from the hospital. Continuity of care implies that the mental health center will help prepare the patient and his family for hospitalization when required, follow his progress, and be ready for his return.

Decentralization and Specialization

Much of the training effort in hospitals has gone to meet the needs imposed by structural change, particularly decentralization, and of new specialized services.

Under decentralization or unitization, as noted earlier, hospital patients are commonly grouped according to the area in which they live, and the responsibility for treating the patients in a given unit is assigned to one team of staff members.

As demonstrated by a number of hospitals serving rural regions and aided by HSD grants—for example, one in North Carolina (*85*) and one in Idaho (*89*)—such organization facilitates continuity of care. When a treatment team is concerned only with patients from a certain area, staff members get to know that area and its resources for sustaining former patients in the community. Likewise, the community comes to understand and work more effectively with the hospital. Adoption of the plan often requires additional training, both to familiarize staff members with regional culture and to enable them to work most effectively with the mental health resources and the people of a particular community.

The increasing specialization of services within mental hospitals also makes demands on the staff that can be met only with further training. As a hospital in Kansas observes: (*86*) "There is a movement toward specialized services such as the new adolescent unit, alcoholism unit, vocational rehabilitation program, and pending children's unit. Each has special needs for training, support, and guidance. . . ." A hospital in the State of Washington (*84*) is using its HSD money in part to train people to staff new programs in drug abuse, a new unit for patients who have broken the law, and a new unit for adolescents. Improved services for children and adolescents are a commonly expressed need.

Some Results of Training Programs

Advances credited to HSD projects include improvement in the morale of staff members and in the quality of their work and a reduction in staff turnover.

For example, one hospital notes that the training program was initially seen as a threat and an indication of unsatisfactory job performance. (*84*) Now, however, it is viewed as an opportunity for learning, and the number of staff members who want to be enrolled exceeds the present capacity. This hospital solicited anonymous evaluation reports from the participants in its training program, and received a number of responses such as this: "At the onset of this conference there was a great deal of fighting, competition, and criticism between social workers vs. nurses; nurses vs. hospital attendants; kitchen vs. ward staff; union vs. management. As a result of the material presented in these workshops, the above-mentioned conflicts have lessened a great deal and a very good working relationship has been established." However, one ex-trainee wrote, perhaps as an indication of the distance still to be travelled: "My own overall commitment to work in mental health programs has increased; however, my desire to work in a State facility has lessened. I feel the majority of staff in State hospitals are too committed to maintaining their job in its present role and function, and less concerned about quality patient care. . . ."

A hospital in California reports: (*90*) "During the first 5 years of grant support, we were able to develop many positive changes in the treatment programs where the training was offered. Improved attitudes toward self and others with the resulting better use of self in working with others and acceptance of change was noted by patients, participants, and supervising personnel. Active treatment programs geared to meet the needs of a certain type of patient have been initiated on many of these wards as skills were developed. Employees have expressed better job satisfaction and shown motivation to obtain further training at their own initiative. Interdisciplinary ward teams are able to work more effectively together as members become more secure in their own roles and communication skills are improved."

Such advances in the effectiveness of hospital personnel have certainly contributed to the decline in mental hospital population noted in the early pages of this chapter. Once in a while it is possible to take some measure of this contribution. For instance, the HSD program at a Kansas hospital (*86*) includes a seminar in which staff members are trained to make a continuing review of patients' charts for the hospital's medical utilization review committee. As a result, during the first 6 months of this review, 87 patients left the hospital, returning to their families or entering nursing homes.

More often, it is impossible to separate the contribution of the staff development program from other measures working for more effective treatment. The case of a State hospital in a predominantly rural region of Louisiana is typical. (*91*) This hospital has reduced its population by about 800 patients in 5 years, and it credits the reduction in large part to the staff development program made possible by an Institute grant. The hospital points out that psychiatric drugs and other factors were important as well; it also points out that modern therapies are of little value unless the personnel primarily responsible for treatment—nurses and aides—know about these therapies and apply them. In this hospital, staff training courses such as those in pharmacology, psychiatric aide techniques, and adult education are voluntary but draw a full attendance and even have waiting lists.

Mental illness is "everybody's business." This is the potentiality we must exploit as a means of resolving the manpower problem.
—*Joint Commission on Mental Illness and Health, final report*

CHAPTER VII

SUPPLYING THE MANPOWER: INNOVATIVE PROGRAMS TO MEET RURAL NEEDS

The delivery of mental health services, the application of research findings, and the pursuit of new knowledge depend on the availability of sufficient manpower dedicated to the field of mental health. So NIMH has a major responsibility to try to help meet the Nation's need for mental health manpower.

Since 1948 the Institute has provided financial support for the training of more than 46,000 people in the four core mental health disciplines of psychiatry, psychology, social work, and nursing, and of more than 6,500 other people in the social and biological sciences, in public health, and in interdisciplinary approaches to mental health work. In addition, medical and nursing school programs in psychiatry, made possible by Institute grants, reach approximately 35,000 medical school students and 30,000 student nurses a year.

Experimental and special training programs supported by the Institute have prepared thousands of other people for work in mental health or have raised the abilities of people already working in this or related fields. These programs have been particularly valuable in training minority group members for work among fellow members and in developing a new type of mental health paraprofessional, one with a degree from a 2-year college.

NIMH training grants provide direct support to public and private nonprofit institutions to help defray teaching costs and to make financial assistance available to students being trained. Participating in the training program are almost all schools of medicine and osteopathy in the United States, most major graduate schools of social work, public health, and nursing, and most graduate departments of psychology. Other participants include many of the Nation's mental hospitals, collegiate schools of nursing, child guidance clinics, research centers, nonprofit psychiatric treatment centers, and institutions for the mentally retarded.

Over the years an unduly large proportion of those graduated from these training centers have chosen to practice in cities. To compensate, the Institute has supported a wide variety of efforts both to improve the skills of mental health professionals and nonprofessionals at work in rural areas and to carry training in mental health principles and practices to other people there—such as physicians, clergymen, and teachers—with a substantial influence on the community's welfare.

This chapter begins with examples of the program known as "continuing education." Of all the training programs the Institute supports, this one probably has made the greatest contribution to the improvement of rural mental health services. The chapter goes on to describe examples of other projects—part of the programs in experimental and special training and in the training of mental health professionals—that are contributing most directly to the development of manpower to serve the mental health needs of people in rural areas.

Continuing Education in Psychiatry

In rural communities, the family physician generally has an intimate knowledge of his patients, their histories, and, often, the histories of their families. His presence during births, deaths, and other crises promotes close, personal relationships—often through several generations. Such relationships place him in a unique position to recognize developing psychiatric disorders and to act on them before they become more serious. He is often the first person consulted by an individual with emotional problems, or by the family or community when a member becomes a problem to others.

The program for continuing education in psychiatry was designed to broaden the ability of family doctors and other nonpsychiatric physicians to recognize and treat emotional disorders. Most projects under this program provide not only training but also consultation, particularly where there are few or no psychiatrists. About 13,000 physicians have participated.

The following sections present examples of this part of the training program as it affects people in rural areas.

Office Psychiatry for the General Practitioner

In Nebraska, nonpsychiatric physicians are offered training in practical clinical psychiatry through an Institute-supported program at the Nebraska Psychiatric Institute of the State University. (*92*) Most of the participants are general practitioners in small, outlying communities who travel to Omaha once a month for an all-day session conducted by the training faculty. The doctors interview patients similar to those seen in their own practice, then follow the patients' progress in therapy by consulting with the therapists and by observing therapy sessions. They also participate in continuing discussions of their own patients, receiving guidance from the faculty and reporting on progress. This training lasts a year.

During the 14 years of the program, 10 percent of the family physicians in Nebraska have been enrolled, and requests for admission have come from physicians in neighboring States. The course is limited to seven participants at any one time, but since 1967 the State has provided additional funds so that two courses can be conducted annually. The geographical representation of the enrollees has corresponded fairly well with the distribution of physicians throughout the State. In the interest of even better representation an aggressive publicity campaign was directed one recent year at practitioners in areas that had not contributed trainees. Of nine communities represented during the following year, seven were new to the program.

Shorter training activities are also part of this project. One is an annual, 2-day program held on campus; it has been attended by physicians not only from Nebraska but also from Iowa, South Dakota, Colorado, Missouri, and Wyoming. Another comprises two, 1-day programs, held each year in outlying regions. For these, faculty members travel to State hospitals to meet with physicians from the area who find it difficult to enroll in longer programs.

Psychiatrists Take Courses to the Rural Physician

Training in psychiatry is being offered to rural physicians in a number of States through short-term courses conducted in remote areas. Examples are the projects in Colorado (*93*) and Wisconsin (*94*) both of which are directed by psychiatrists on the staffs of the State medical schools with the cooperation of individuals and groups throughout the State. In Wisconsin, courses are given in local hospitals by either university or local psychiatrists. In Colorado, each course is taught by one psychiatrist from the medical school in Denver and one who practices near the area where the course is held. Traveling by commercial airline and chartered planes, the medical school psychiatrists have covered most of the State, conducting courses wherever they could get groups of eight or 10 physicians together. The doctors meet for 2 or 3 hours a week over a period of from 8 to 12 weeks.

Most of the participants in these courses customarily have referred patients with mental health problems to urban psychiatrists, private sanitariums, or State mental hospitals. In the training projects they gain a general understanding of mental illness and emotional problems, a knowledge of psychiatric drugs and their use, the ability to recognize psychiatric emergencies, and some improvement in the ability to handle patients with psychiatric problems.

In Wisconsin a second course with the same format as the first is given in each location. Psychiatric subspecialists offer further training in family therapy, child psychiatry, or other areas, and community and institutional representatives describe their services and suggest techniques for managing discharged patients. In Colorado, physicians completing the basic course may sign up for regular consultation sessions with the project's psychiatrists.

A program differing in the size of the territory covered and in the variety of approaches offered but having the same essential purpose—to bring psychiatric knowledge and techniques to the rural doctor—is being conducted by the University of Utah for physicians throughout Utah, Idaho, Montana, Western Wyoming, Eastern Nevada, and Alaska. (95) The program was initiated in 1959 by a psychiatrist who travelled, mainly by car, through the first four of those States, meeting many of the physicians in isolated areas and holding informal seminars with small groups. Now the airplane has largely replaced the automobile, and the training activities have been extended into Nevada and Alaska.

The program offers three types of activities: formal lectures, workshops lasting from 1 to 3 days, and continuing seminars. In the seminars, psychiatrists from Salt Lake City meet with small groups on a regular basis and discuss case material brought in by the members or seen on medical college videotapes. In the more isolated areas, particularly those that can be reached by chartered but not commercial aircraft, seminars may meet once a month; elsewhere, as often as once a week. Generally this type of program continues for several years. Project psychiatrists believe that the continuing seminars are the most effective approach to postgraduate psychiatric education but that the lectures and workshops can be of value to physicians unable to participate in seminars.

During a recent year more than 2,100 physicians participated in the 172 programs conducted throughout the area. Included were 29 lectures to medical societies and groups of nonpsychiatric physicians and eight workshops, presented with the aid of local psychiatrists.

Psychiatric Consultation From a Circuit-Rider

In the Appalachian Mountain region of North Carolina, a circuit-riding psychiatrist began in 1964 to provide consultation to local physicians on the treatment of patients with emotional problems, and thereby to demonstrate still another way of furthering the education of practicing doctors. (*96*) Under an institute grant, Dr. James Cathell, a native of North Carolina and a general practitioner for 11 years before turning to psychiatry, traveled through the mountain communities spending a few hours with each physician in the physician's own office or at a community hospital discussing the physician's patients and working out a plan of treatment.

Under the auspices of the State's Department of Mental Health, the program was started through meetings with Western North Carolina medical societies. Eventually, 64 of the 68 physicians serving the five-county area of 140,000 people began taking an active part. The consultant scheduled regular monthly visits with each physician and gave out copies of his route so that he could be reached by telephone at any time. The availability of telephone consultation did much to persuade the physicians to accept the responsibility for treating patients they ordinarily would have sent elsewhere. The consultant made no attempt to take over their treatment; he simply provided information on psychiatric principles, on the use of local agencies, and on treatment methods, including psychiatric drugs.

Dr. Cathell believed that there was no such person as a nonpsychiatric physician. "Many physicians use psychiatric procedures unconsciously and intuitively," he said, "but because they do not realize this, they are not always correct or efficient in their use." He believed that a family physician, though not trained in classical psychotherapy, was in an ideal position to provide supportive therapy as well as environmental manipulation through local agencies, the family, or neighbors. "In his approach to psychiatric illness," he said, "the average family physician uses techniques that are more directive or authoritative than those used by psychiatrists. Most general practitioners are more pragmatic, and are oriented to concrete, specific action. Their approach seems intuitive—at least, they often have trouble describing what they do. But what they do works—often quickly—and with methods that are comfortable to patient and physician alike."

The consultation program works to reinforce rather than alter those methods. The physician learns to evaluate cases earlier and more accurately and to distinguish between cases that require hospital care and those that can be handled in the office. He is encouraged to plan a program of treatment and make a realistic prognosis. By setting realistic goals, he learns, he may avoid much frustration for both himself and his patient and develop a more positive attitude toward the treatment of chronic psychiatric illness.

In a total approach to mental health care, the North Carolina physicians are encouraged to mobilize all needed and available community services, including public health nurses, social workers, welfare agencies, homemaker services, rehabilitation workers, clergymen, school counselors, and neighbors, friends and families. Public health nurses have been especially valuable in keeping tabs on patients in some of the more remote areas.

In 1967, Dr. Cathell turned over his mountain circuit to another consultant and took his methods across the State to test them in the more urbanized eastern area. In 1970 he died, but the traveling-psychiatrist program continues. During his 3-year tour in the mountains he reviewed 4,000 cases with local physicians. During the first 2 years of the program, admissions from the five-county area to the Broughton State Mental Hospital at Morgantown decreased 25 percent, while admissions from other counties served by the same hospital more than doubled. At the same time the psychiatric admissions to local general hospitals in the 5-county area increased from 10 percent of all admissions to 30 percent. Emotional problems which once sent many persons to a State institution were being dealt with at home.

Regional Efforts to Develop Continuing Education for Physicians

In 14 southern States the Institute has supported psychiatric training programs for general practitioners since 1959 under the auspices of the Southern Regional Educational Board. (*97*) Approximately 20 such programs are under way, and the Board is now engaged in assisting the planners, coordinators, and instructors to improve them. The effort includes an annual teaching conference for 45 southern psychiatrists to review teaching methods, to discuss how the problems of meeting mental health needs vary from rural area to small town to the big city, and to examine the common psychological and sociological problems likely to confront the general practitioner. Twice a year, small workshops are held to consider the continuing education needs of certain groups, such as pediatricians or rural general practitioners.

Another regional effort to develop continuing education in psychiatry for nonpsychiatric physicians is supported in 13 western States through the Western Interstate Commission for Higher Education. (*98*) Since 1960, when it convened its first seminar for nonpsychiatric physicians, this organization has sponsored a dozen or more seminars annually. Departments of psychiatry in almost every western medical school now offer continuing education courses for physicians.

New Directions in Continuing Education

Continuing education projects similar to those for physicians have been supported since 1966 for people in other fields. The goals are to help mental health specialists keep abreast of advances in theory and practice and to prepare people in related fields for more effective service as members of the mental health team. Community mental health services are a major concern. For example, an Institute-supported program at the University of North Carolina provides training in planning and operating community health centers and other community mental health programs to students from a wide variety of professional backgrounds and from throughout the Southeastern States. (*99*)

Other examples of projects having a clear influence on rural areas are noted below.

Teachers of Mexican-American Children

In Western Texas, a program for teachers of Mexican-American children aims to change the students—so that they will feel better about themselves and have better attitudes toward school and education—by changing the teachers' behavior toward them. (*100*)

The program is being conducted by the West Texas Education Center, which serves 38 school districts in an area as large as Indiana but with only a third of a million people. Half the people live on farms or ranches or in small towns. In the region's Mexican-American homes, the adults have averaged less than 4 years of school, and the children commonly have severe cultural and language deficiencies, particularly when measured by Anglo-American standards, which are those of the schools. The child who conforms to the teachers' expectations for Anglo children succeeds in school; the child who doesn't conform is likely to fail. Too often, lack of acceptance and understanding by the teacher makes failure more nearly certain.

This pilot training program began with a 2-week institute for representatives from each of eight elementary schools. About 500, or more than half, of the children in these schools are Mexican-American. The institute included personal sensitivity sessions, to foster self-understanding and an awareness of one's impact on others; cultural sensitivity sessions, to help the teachers understand the attitudes and perceptions of minority group members; interaction with parents and children from the community; and discussions of how the curriculum could be improved. Tests indicated that the participants' attitudes had become more conducive to the development of friendly relations between teacher and students. After the institute a series of followup workshops was scheduled for each school.

Secularly Employed Clergy

Of the 4,000 clergymen in South Carolina, about 1,000 are secularly employed, which means that they hold a job during the week and conduct church services in the evenings and on weekends. They serve mainly small rural churches, performing various pastoral functions as their time and ability allow. Some have less than a high school diploma; few have received extensive theological training. Since virtually all are looked to for leadership in their communities, they constitute a potentially very rich mental health resource, which one community mental health center proposes to tap by means of a continuing education program in community mental health concepts and family life education. (*101*)

Participating in the program undertaken by the Spartanburg Area Mental Health Center are 20 rural pastors from Cherokee County, which has no psychiatrists but does have 130 clergymen—serving a population of 35,000—of whom 75 are secularly employed. The participants are offered educational opportunities and guidance over a 3-year period to enhance their pastoral skills. Included in the program are weekly small-group sessions and weekly individual consultation by the training program director. In addition to increasing the clergymen's ability to counsel their parishioners when family life crises arise, the project is expected to open new routes of communication between rural communities and the mental health center.

Community Caregivers

In Michigan's Upper Peninsula, a rural area three times as large as Connecticut with a thinly dispersed population and many isolated communities, a continuing education program is helping to meet mental health needs by elevating the skills of community caregivers—including teachers, social workers, doctors, clergymen, nurses, rehabilitation counselors, and the staff of such programs as Job Corps and Neighborhood Youth Corps. (*102*)

This training program, initiated by Northern Michigan University in cooperation with the Marquette Community Mental Health Center, is based on the concept that crisis periods may lead either to continued growth or to maladaptive reactions, resulting eventually in serious emotional problems, and that an effective caregiver can step in during the crisis period and prevent or at least lighten such reactions. Groups go to the university campus for workshops ranging in length from 3 to 10 days. Teaching methods include role playing, systematic observation, case conferences, and observation of the work of the mental health center's consultation teams. The teachers include members of the university faculty and of the center staff. The availability of help from the center's consultation program is emphasized.

Analyzing and Meeting Needs

Another NIMH grant has led to the development of a Mental Health Training Institute serving North Carolina's Eastern Region—33 largely rural counties. (*103*) Based at East Carolina University, the institute is a collaborative effort of the university and the State's Department of Mental Health. It seeks not only to provide continuing education but also to analyze the region's training needs and to evaluate the training programs offered to meet them. Four target groups have been identified: Mental health professionals in community mental health centers and clinics; secretaries and supporting staff; mental health professionals and subprofessionals in regional institutions, including psychiatric aides, vocational rehabilitation counselors, and allied staff; and key professional groups, including nonpsychiatric physicians, clergymen, law enforcement staff, school personnel, public health workers, and welfare workers.

The project intends to focus on such issues as whether or not the expressed training needs of mental health programs are related to the actual needs of the community and are reflected in the developing programs of the Mental Health Training Institute.

At the University of New Mexico where a similar effort is being made, surveys of needs have been followed by the development of continuing education programs throughout the State. (*104*) The concepts of mental health and their application to communities are presented through statewide institutes and seminars, community workshops, field experiences, and inservice training.

In addition, a team travels to selected areas on a regular basis to help participants build upon the initial learning experience.

Experimental and Special Training Programs

The Institute supports a rich variety of projects that are trying to alleviate the shortage of mental health manpower by developing more effective training methods and by opening up new manpower sources. Each project is an experiment to test whether or not an apparently valuable approach to the problem will work. If it does, it serves as a model for other projects. The projects described in this section are efforts to bring more people—particularly, in most cases, more rural people—into the mental health manpower pool.

Training Mental Health Workers in Community Colleges

The experimental program with the greatest initial impact was a 2-year college course to train mental health workers. The program began with an Institute grant to Purdue University in 1966, quickly followed by grants to six other institutions. (*105*) The intent was to demonstrate that people could be trained in 2-year colleges to become mental health specialists capable of working in comprehensive community mental health centers and a wide array of other mental health settings. The educational program combined liberal arts courses with courses in subjects pertinent to mental health work and with field experience. Such training holds special promise for improving services in rural areas because the students in community colleges are largely from the surrounding region and usually intend to remain there.

During the 6 years following the grant to Purdue, more than 100 training programs were developed in community colleges across the Nation with local support and usually with consultative help from NIMH-supported programs. As of September 1972, more than 2000 persons, many of them long out of school, were enrolled in such programs, which lead to an Associate of Arts or similar degree. Graduates have had little trouble finding employment.

NIMH in 1970 began expanding its support of similar programs. In deciding among competing requests for grants, it now gives priority consideration to programs emphasizing the training of disadvantaged persons, training for services in community-based settings, and training for service to deprived populations, urban or rural. These priorities are in line with the Institute's commitment to increase its support of training programs for "new careerists" in mental health, defined as disadvantaged individuals being prepared to take over some of the work that commonly has been done by professionals.

One of the new programs is at Gadsden State Junior College, in Gadsden, Alabama, which serves an eight-county area in the Appalachian region and draws about half its students from small towns and rural areas. (*106*) Of the people entering the new mental health training program there, an estimated 50 percent or more are economically and educationally disadvantaged. Gadsden is also the site of a new community mental health center serving three counties where the median family income is less than $3,500. The trainees will get their practical experience primarily in this mental health center, and the graduates will be needed both in this center and in others being planned for the area served by the college. Students are trained to participate in such activities as therapy, community and outreach work, interviews, record keeping, patient care, and planning and directing new or lower-level workers.

In the western States, The Western Interstate Commission on Higher Education is working with NIMH support to stimulate and give direction to a number of community college programs (*107*) The Commission emphasizes the desirability of recruiting as students those individuals whose skills and life experiences stamp them as excellent learners and potential contributors to the helping field even though they lack high school credentials. The recruitment of Indians and Spanish-Americans is emphasized.

Mental health workers can go beyond a 2-year degree. With NIMH support, the Maryland Consortium for Health Sciences has undertaken a project to provide training opportunities at the BS and MS levels for graduates of 2-year programs. (*108*) The training is closely coordinated with the job opportunities in mental health service agencies. This project represents a logical progression in the Institute's support of community college programs and could serve as a national model for integrating training with career opportunities.

Pharmacists as Mental Health Professionals

An effort to develop pharmacists who will be more than usually effective as public health and mental health professionals—in some small towns the only ones on the scene—is under way in Tennessee, where the college of pharmacy at the State university has instituted a program in clinical pharmacy. (*109*) The intention is to train pharmacists who will view the people on the other side of the counter not as customers and potential buyers of merchandise but as individuals whose health and welfare are of concern.

The program is based on the belief that pharmacists are in a position to contribute more actively in the delivery of health services, mental as well as general, because they are available to a large number of people and because considerable information about the health and well-being of individuals and families comes to their attention. Pharmacists often counsel and provide information about drugs to physicians, nurses, and patients and, in the absence of a physician or in an emergency, they render first aid. When confronted by problems or questions outside their professional, legal, or ethical bounds, they refer clients to an appropriate practitioner. With training, pharmacists can make similar contributions in the field of mental health. They can become advisors to mental health professionals by being alert to prescription drug abuses, discontinuations of necessary medication, and signs of adverse drug reactions or behavioral modifications; they can recognize crises in an emergency, and intervene.

In the Tennessee project, social and behavioral science topics are included in the basic pharmacy curriculum and are taught by social workers, clinical psychologists, and psychiatrists. Field experiences are provided in a hospital, an outpatient clinic, a comprehensive health care project for children, and a suicide prevention service.

Elementary School Teachers as Child Development Specialists

Florida State University is training child development specialists for work in rural areas of northern Florida that lack adequate specialized helping resources. (*110*) Trainees are drawn from the faculties of elementary schools within commuting distance of the University, an area that includes 10 rural counties. The local school systems select teachers for participation, grant them a year's leave of absence for on-campus training, allow them to spend the first seven months of the second year interning as child development specialists in their home school or county, and rehire them in April as child development specialists. The training leads to an interdepartmental master's degree in human development.

During their year at the University, in addition to studying the principles of child growth and development, the trainees become acquainted with public health and social welfare facilities and procedures, clinics for children, a variety of schools, and special classes and institutions for retarded children. As child development specialists they will work primarily with teachers, from kindergarten through third grade, and serve an advocacy function in schools and communities on behalf of children.

Workshops for Caregivers

In Georgia, a project to bring together the caregivers of a small community in order to increase their skills and open the way to a coordinated effort to promote mental health has reached more than a thousand persons. (*111*)

Clergymen, public health nurses, case workers, school personnel, and others have been meeting together in groups of a dozen or so within their own communities 2 hours each week for 10 consecutive weeks. The sessions, called workshops, are basically group discussions of the troubled individuals or families each participant is trying to help and of the possibilities for doing so most effectively. An instructor from a psychiatric center in Columbus, Georgia, attends the workshops, makes suggestions, and provides additional case consultation to trainees by phone or mail.

A Program to Help Perpetuate Navajo Medicine

In Arizona, NIMH support is enabling Navajo medicine men to train apprentices so that the Navajo people's ancient, traditional medicine, on the verge of extinction, can be perpetuated at least in part. (*112*) This training project is unusually important both for its potential influence on the psychic and physical health of the whole community and for what the venture has to teach of the value of integrating the goals and techniques of traditional medicine—in the Indian and other areas where such medicine is still important—with those of contemporary medicine.[1]

In the past, a Navajo who wanted to learn one of the longer healing ceremonies would spend several winters with a medicine man and pay him with food, livestock, and perhaps his first fees when he was able to practice. Now the lack of money and jobs around Black Mountain, Rough Rock, and Many Farms, Arizona, has made it impossible for younger men to undertake this training.

To master an elaborate ceremony a trainee must learn, entirely by rote and through observation, as much information as he would be required to know for a Ph.D. He must learn legends, hundreds of chants and prayers, and a pharmacopaeia of 150 to 200 herbs; he must also learn how to create intricate, symbolic sand paintings.

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[1] This section is drawn from Luce, Gay. The importance of psychic medicine: Training Navajo medicine men. In: *Mental Health Program Reports—5*, DHEW Publication No. (HSM) 72-9042. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office.

Each medicine man is a specialist, for out of a total of 45 or 50 ceremonials, not even the most learned man knows more than four or five.

There are six medicine men in the NIMH-supported program, and each is training two apprentices in one of the important ceremonials. The instruction takes place in the medicine man's hogan. As part of the program, also, the entire group is receiving instruction in white medicine. Every 2 weeks the Indians meet at the Rough Rock Demonstration School, where they learn about internal medicine, bacteriology, viruses, cancer, X-ray, nutrition, psychiatry and other subjects from the director of the mental health projects on the Navajo reservations.

Medicine men use both tangible and symbolic remedies. They set fractured bones and administer a wide variety of herbs to counteract fever, insomnia, and pain, but their most important impact is psychic. Although they are eager for the most part to cooperate with modern medical clinics, their own sphere of influence extends beyond medicine to the restoration of a sense of health and integrity and of harmony with one's family, clan, and universe.

> The premises of Navajo life are almost the antipodes of the American code. Family and clan are the all-important units of life. . . . In crisis and under pressure, the white American code says "do something," without specifying what. Navajo culture says the opposite. Instead of fighting, escape, and instead of action, do nothing—passive resistance. If Americans seek to tame nature, Navajos seek to live in respectful harmony, lest nature destroy them. If Americans encourage individualism, the Navajos encourage cooperation and respect for the individual. In family situations, husbands and wives do not try to control each other, and children are consulted in matters regarding them. . . . Security comes from group respect and cooperation, beginning with the family. Love of life and adherence to tradition are more important than work and technical innovation. Navajo people accord prestige to a person who knows many songs, as well as to one who owns (for his family) many turquoises. . . .[9]

Many of the concepts of psychoanalysis appear in Navajo medicine, and the ceremonies include some elements resembling family therapy and others resembling sensitivity sessions. Some of the longer ceremonies, lasting 9 nights and 10 days, resemble the compressed therapy of the encounter marathon. Moreover, the ceremonies selected for the individual contain mythological and symbolic components that are suited to the psychodynamics of the patient's illness. They turn the despairing toward health.

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[9] See footnote, preceding page.

Medicine men are combinations of physicians, teachers, psychiatrists, artists, and priests. Among a people with a group orientation to living, where decisions are made by consensus without centralized authority, medicine men are the cultural leaders—the carriers of tribal knowledge, pharmacology, and symbolism. Without them, traditions would vanish. Although many Navajos live in two very different worlds, even the most acculturated members gain sustenance from the ceremonies.

Northern Cheyennes as Mental Health Workers

A different kind of effort to develop community mental health workers who can meet the needs of an Indian population is underway in Montana, where 10 Northern Cheyenne Indians are in training to serve as intermediaries between outside professionals and the reservation population, which has very high rates of alcoholism and suicide. (*113*) This project creates the positions, fills them with members of the Northern Cheyenne tribe who live on the reservation, trains these individuals to function as assistants to mental health personnel, and helps them develop their skills as mental health workers to whatever degree their interest, motivation, and intelligence allow.

The 2-year training period is split into smaller periods that alternate between academic training at Montana State University and work on the reservation. Although formal course work can be incorporated into an individual's training program, the basic academic training is informal, carries no credits, and after one academic quarter of introductory material is determined solely by the needs of the trainees in relation to the work they have been doing on the reservation.

Both the training experience and the role of the mental health workers are being kept as unstructured as possible so that the project, which is Indian-run and Indian-evaluated, can develop a mental health model appropriate to Indian needs there and on other Plains Indian reservations.

Public Service Careers: Indian Alcoholism Project

Another venture of pertinence here, though not part of the same administrative program, is the Indian Alcoholism Training Project at Warm Springs Hospital, Montana, which is preparing people for field work on Indian reservations. The trainees are Indians who have been alcoholics.

The goal during 2 months of inhospital training is to help the trainees determine, through their own experience as Indians and alcoholics, what tools are necessary to combat alcoholism on their reservations. Following the inhospital program the trainees have six months of supervised field work. Graduates of the program, in which 24 persons from five Montana reservations were enrolled during the first year, become outreach-workers among fellow Indians.

The hospital notes that the program has developed an important by-product—"more understanding of the special problems of the Indian people by the institution and more understanding of the institution by the Indian community."

This project is part of the New Mental Health Careers Program, administered by NIMH under an agreement with the Department of Labor, which provides the financing. That program, in turn, is part of the Manpower Administration's Public Service Careers Program, which was designed "to help secure, within merit principles, permanent employment for disadvantaged persons in Governmental agencies at all levels, and to stimulate the upgrading of current employees, thereby meeting public sector manpower needs." The program hopes to achieve these aims by providing funds to State and local governments and Federal agencies to be used in innovative projects directed toward overcoming or eliminating those barriers which now prevent the most effective and efficient use of human resources in public service.

During the first year of the New Mental Health Careers Program, 1970–71, a dozen training projects were in operation under the direct supervision of a variety of mental health systems, including State hospitals, community mental health centers, and a medical college.

Training Mental Health Professionals

Continued improvement in the quality of mental health services to our rural population and in the proportion of the rural population reached by these services depends in part upon a continuing increase in the supply of professionally educated mental health workers. These include social and biological scientists to uncover the knowledge needed for more effective efforts against mental illness and related problems and to help educate a new generation of scientists. They also include psychiatrists, psychologists, psychiatric social workers, and psychiatric nurses to provide services, to guide less fully trained members of the mental health team, to train both professionals and paraprofessionals, and in many cases to participate in research looking toward improvement in the delivery of mental health services.

The Institute supports large training programs to increase the quality and the quantity of professionals in all mental health fields. This section is limited to projects in the four basic mental health disciplines that have a direct influence on service to rural communities and may serve as models for future projects.

In Psychiatry

The Institute supports training in psychiatry in order to increase the number of psychiatrists, to improve the quality of their training, and to advance the teaching of psychiatric principles and skills to medical students or nonpsychiatric physicians. While the program is intended to benefit, ultimately, people everywhere who need mental health services, we know that the vast majority of psychiatrists and a substantial majority of other physicians practice in urban areas. Chapters III and V noted some of the ways used in rural communities to compensate for the shortage of psychiatrists and other mental health professionals.

One of the few training projects in psychiatry specifically designed to introduce students to the special needs of rural areas is part of the child psychiatry program at the University of Kentucky. (*114*) The goal is to develop child psychiatrists able to work in a variety of settings—including clinics, inpatient wards, and community mental health programs—both urban and rural.

As part of their training, students work with a service-training-research project undertaken by the university's department of psychiatry and four county health departments. The project operates two child-psychiatry clinics that serve a largely rural, low-income population in eastern Kentucky. There the students learn to deal with the problems of Southern Appalachian families and to work in collaboration with public health nurses, school personnel, public assistance workers, child welfare workers, and family physicians.

The training also includes case consultation to various child-care agencies in the city of Lexington and in a 14-county region. Each child-psychiatry fellow in training serves for a year as a consultant to several of these agencies.

Four other NIMH-supported psychiatric training programs under way at the University of Kentucky—in basic residency, GP residency, undergraduate psychiatry, and undergraduate human behavior—also provide students with a foundation for practicing psychiatry with a rural population. Students in the basic residency program, (*115*) for instance, spend 1 day a week in a rural county health department, where they are involved in child and family, school, and community aspects of psychiatry.

Another psychiatry project that gives students experience in meeting mental health problems of rural areas began recently as part of the undergraduate curriculum at Yale University Medical

School. (*116*) The program includes clinical experience with mental health teams working in two different cultural settings. One is rural—the Navajo reservation in Northern Arizona. The other is intended to be urban—the economically and socially deprived minority groups served by the New Haven, Connecticut, Mental Health Center. But a student wishing to contrast two rural areas may be offered an opportunity to work at a second rural facility. Three months will be spent in each setting, half of the time in clinical work and half in a research project to objectify clinical impressions.

In Psychology

As part of the efforts to overcome the severe shortage of professional manpower in rural areas, it may be necessary to provide graduate training specifically designed to prepare people to work in those areas. Recently the Institute began supporting such a training program at the University of Wyoming. (*117*) It is a 4-year program in rural community psychology leading to the Ph.D. in psychology. Along with the usual training in clinical and research skills, it emphasizes the development of skills involved in community work, such as programming, consultation, community organization, and public education.

Each summer, students in this program serve 3-month clerkships in community agencies in Wyoming, Colorado, or Nebraska. The goal is not only to develop skills but also to enable the student to learn about the programs, clients, and problems of an agency he may eventually work with or provide consultation services to, and to foster ties that will encourage him to remain in the region after he has completed his training.

A number of other Institute-supported projects offer students an opportunity for supervised clinical experience in a rural setting. In northwestern Illinois an internship program in community-clinical psychology provides experience with a variety of agencies serving a ten-county region. (*118*) In southwestern Ohio, as part of the clinical program of Miami University of Ohio, a clinic has been developed that serves as the central resource for training and outreach services in rural areas of that section. (*119*) Trainees and faculty have been working with policemen, probation officers, city officials, teachers and school counselors, clergymen, welfare workers, physicians, attorneys, and numerous other care-giving personnel. In Tennessee, the clinical program of the State university is involved with several community agencies in and around Knoxville, some of them serving the rural Appalachian counties. (*120*) Faculty members and students travel to outlying regions for consultation with schools, juvenile courts, and homes for wayward children. They work, too, at a rehabilitation center that serves rural northwestern Tennessee as an outpatent clinic and as a school for multiply handicapped children and adults.

In North Carolina two training programs in clinical psychology are heavily involved in serving the mental health needs of rural communities. The one at Duke University has developed a program of community consultation that has been particularly concerned with problems in the schools. (*121*) For example, faculty members and trainees have helped the residents of one rural county develop an ungraded primary class and a mental health facility, have participated in the development of a tutoring program, and have trained teachers to apply mental health principles in the classroom. At the University of North Carolina the clinical psychology program has taken over direct responsibility for the operation of a small mental health facility in a rural community. (*122*) Consultative relationships have been established with the schools, the county commissioners, the courts, the county welfare planning agency, aftercare services, and local physicians. Families may be seen directly. Each consultative area is the responsibility of a different faculty member, who guides the students' work in that area.

At the Astor Home for Children, Rhinebeck, N.Y., the only child mental health facility in a wide area, predoctoral field training in clinical psychology is provided students from various parts of the country. (*123*) The training program includes the delivery of services—in cooperation with the Dutchess County Mental Health Center in Poughkeepsie—to troubled children and their families throughout the county and the surrounding rural areas in the Hudson Valley region. The psychology interns also help provide consultation to schools, hospitals, and colleges, and they work with children at the home, which, in addition to its community efforts, serves as a residential treatment center, primarily for disadvantaged children from New York City.

Numerous programs either to help psychologists meet the needs of minority groups or to enable members of these groups to become psychologists, or both, have been made possible by grants from the Institute.

In Arizona, a community mental health clinic has been established on the Papago Indian Reservation as part of the clinical psychology training program at the University of Arizona, in Tucson. (*124*) The clinic is staffed by university faculty members, two advanced graduate students, and a full-time Papago mental health worker. Students have an opportunity to participate in consultation to local school administrators and teachers, tribal courts and police, health service personnel, and Papago medicine men. As part of the same training program, another clinic provides services to Mexican-Americans. The program emphasizes respect for the individual, his culture, and his identification of his needs.

In Hawaii, psychology interns travel routinely to the mental health clinics on the outer islands, where they serve in a consultative role to the schools, police, clinics, and courts. (*125*) It is a unique training experience because of the range of ethnic groups with which the trainee comes in contact. Development of an understanding of cultural influences on personality and on personality disturbances is encouraged.

A new program at the University of South Carolina provides summer training for undergraduates from southern black colleges to prepare them for graduate school training in psychology. (*126*) A consortium of black schools in Atlanta is developing a graduate training program in community psychology. (*127*) At Southern University, in Baton Rouge, a program prepares black students either for effective service roles after graduation or for graduate work. (*128*) A program at Fisk University and Meharry Medical College is designed to pool the academic resources of one educational institution and the professional training resources of another to increase the number of black psychologists at the master's level to help meet the needs of disadvantaged people, urban or rural. (*129*)

In Social Work

Social work practice in rural areas poses special challenges and opportunities because these areas often lack the network of social welfare services available elsewhere. Consequently, a number of the Institute-financed training programs in social work give students an opportunity for experience in a rural setting.

In West Virginia, social work students at the State university are placed in one of the decentralized offices of the Appalachian Mental Health Center, at Elkins—which serves a 10-county region—where they come to grips with the mental health problems common to isolated and depressed areas. (*130*) The students participate in such activities as individual and group counseling, premarital counseling, and mental health education programs for public health personnel, clergymen, and other community caregivers. They also follow patients admitted to the State hospital and continue with them upon their discharge.

Louisiana State University maintains a rural-based field instruction unit which is housed with the department of public welfare of Ascension Parish and works both with that department and the satellite of the East Baton Rouge Mental Health Center. (*131*) The trainees carry case assignments from both agencies. They work with families on a range of problems that include disturbed relationships, behavioral and learning problems, delinquency, illegitimacy, poverty, and alcoholism. They sometimes counsel individuals as well. The trainees also work with groups of mothers on problems of home management and child rearing, and they consult with school teachers on problem children and problem parents and with teachers and student leaders on interracial relationships.

In Howard County, Missouri, the State university's school of social work operates a field training unit that is affiliated with the Mid-Missouri Mental Health Center. (*132*) As part of their training, graduate social work students in the unit get to provide outpatient, inpatient, and aftercare services and to work with community groups. In California, social work students of Fresno State College are offered field training at the county's only year-round day care center for pre-school children of farm labor families. (*133*) All of the children enrolled are from Mexican-American families. The trainees serve as advocates for these people, helping them get needed services from welfare, health, probation, and other agencies. The trainees also work with individual preschool children, with the parents and families, and with groups of teenagers.

Among new projects that will expand training opportunities for work in either urban or rural community mental health agencies are two in Texas, one of them in a predominantly black community where a mental health center is being established (*134*) and the other in a public housing project with a low-income Mexican-American population. (*135*) A new school of social work in California will be staffed mainly by Mexican-American teachers and will have a predominantly Mexican-American student body. (*136*)

In a unique example of cooperation among three partners—two States and the Federal Government—the University of Utah School of Social Work offers training designed to increase the supply of professionally trained social workers for Alaska, which has no graduate school of social work. (*137*) The program is open to native Alaskans—Eskimos, Indians, Aleuts, and Caucasians—and others who would like to work in Alaska. Over a 5-year period, about 40 students will be recruited from the Alaska college population for training in social work in areas that are both rural and bicultural.

Although Alaskans refer to the "lower 48" as the "smaller States," some areas of Utah resemble areas of Alaska in their spaciousness, their thinly distributed population, and their varied ethnic and cultural groups. In such areas, which include Navajo and Ute Indians among the population, students in the project receive field instruction. Close liaison is maintained with undergraduate programs at the University of Alaska and Alaska Methodist University and with service agencies in Alaska, where some students work during the summer. A number of students travel each month with the State of Utah's traveling mental health clinic teams. Others get experience with a Federally supported project serving rural school districts, or at the University's field instruction unit on the Fort Duchesne Indian Reservation, a community of 1,500 Ute Indians.

The project is designed to train social workers not only for direct service in Alaska but also for State administrative and field positions and for such responsibilities as staff training, program interpretation at the community level, recruitment and training of volunteers, project development, and work with schools in rural areas.

In Psychiatric Nursing

Institute-supported programs in nursing provide training at both the graduate and undergraduate level. Graduate programs provide training in psychiatric nursing for clinical practice, teaching, supervision, administration, research, and consultation. Undergraduate programs incorporate mental health concepts into the basic nursing curriculum and serve to increase the number of nurses who decide to continue their education in the mental health field. While probably at least a few of the graduates of any one of these programs will go on to serve rural patients, this section of the report is concerned with four programs—two undergraduate and two graduate—at institutions strategically located to offer a rural training experience.

One of the undergraduate nursing programs is at Berea College, Berea, Kentucky. This school has been providing low-cost education for students from the Southern Appalachian region since shortly after the turn of the century. (*138*) The nursing major is built upon a liberal arts, natural science, and social science foundation. Sociopsychiatric content is part of all clinical courses. Among the requirements is a semester devoted to psychiatric nursing, with clinical work at Eastern State Hospital, in Lexington. The 1-hour drive to and from the hospital is made in bus-like vehicles equipped with microphones so that students and faculty members can discuss their interactions with patients. Senior nursing students, sometimes living for a while in mountain communities, do public health work with patients discharged from mental hospitals. Throughout the program students are encouraged to identify the health needs of people in the Southern Appalachians and to work toward their solution.

Another undergraduate program is supported at Prairie View A&M College, Texas, a small land grant college established in 1878 that serves a primarily rural black population. (*139*) The school of nursing, opened in 1952, educates 70 percent of all the black nurses receiving bachelor's degrees in Texas. In the senior year a course in psychiatric nursing uses the Houston Veterans Administration Hospital for practical work, and a course in public health nursing offers experience in the rural areas. NIMH also supports the Texas Nurses Association in a project to recruit and maintain Mexican-American and black students in professional nursing programs.

A graduate program at Arizona State University is designed to prepare nursing specialists capable of providing leadership for community mental health programs in Arizona and other southwestern States. (*140*) During the 2-year program, which leads to an M.S. degree, nurses study social systems theory, community organization and planning, community mental health nursing, human development, and community research. They gain practical experience in community mental health centers and programs in urban and rural poverty areas in and around Phoenix, including the Maricopa Indian reservation.

Graduate level training is being offered to school nurses in Alaska through a summer program sponsored by the Alaska Methodist University. (*141*) Annual 3-week workshops provide training for about 35 nurses in contemporary concepts of mental health and psychiatric nursing, with the goal of improving their ability to prevent and treat emotional difficulties among school children. When the workshops were started, in the summer of 1969, the State had no professional educational program of nursing, so nurses who wanted to improve their abilities through formal education had to go elsewhere. Each nurse in the workshop, besides participating in discussions of child growth and development, group dynamics, and counseling, works with one child in an institutional care and training setting. In group sessions the school nurses have an opportunity to discuss their local programs and to meet with people in related disciplines, such as public health nurses, counselors, administrators, and special teachers.

> *The rung of a ladder was never*
> *meant to rest upon, but only to hold*
> *a man's foot long enough to enable*
> *him to put the other somewhat higher.*
> —*Thomas Henry Huxley*

CHAPTER VIII

A SUMMARY AND A QUICK LOOK AHEAD

Chapter I

One-fourth of our people live in rural America, where they may enjoy certain advantages over their cousins in the city. Rural America, compared to urban, however, has far greater proportions of poor people who have had little schooling and of people with inadequate housing. The prevalence of activity-limiting chronic conditions is greater, and the shortages of professional health manpower—particularly mental health manpower—more severe.

Chapter II

To reduce the toll of mental illness and to help people raise the quality of their lives, the National Institute of Mental Health supports research, service, and manpower training programs for the benefit of rural and urban residents alike. And it supports other programs intended specifically for one of the two groups.

Research directed specifically toward improving the mental health of rural America includes epidemiological and demographic studies, to assess the extent of mental and emotional disorders and to determine what groups of people need help most; surveys of attitudes toward mental illness and mental health services; investigations of the effects of urbanization; and studies of rural delinquency and rural suicide rates. Psychiatric impairment in rural areas, several investigators have found, is most common among people of low socioeconomic status. In samples from three States, it ranged from 17 to 41 percent. It was lower than in previously studied urban areas. It was higher among blacks than whites. There is evidence that rural people hold more realistic views about mental illness than formerly and welcome mental health services. Groups rating relatively high on a scale measuring the degree of stigma attached to mental illness, one research team reports, include people in the open country as compared to those in rural settlements, nonwhites, older people, and people of low income or little education. Another team, studying several hundred rural boys, finds evidence linking delinquency to academic failure, and it attributes this failure in large part to the schools. Other studies find rural suicide rates to be higher than urban, and one reports differences between the person who only thinks about suicide and the one who attempts it. Studies of American Indians are leading to findings useful in helping these largely rural people overcome widespread mental health problems.

Chapter III

As part of its program to improve rural mental health services, NIMH has supported a number of research demonstration projects intended to close the gap long existing between the State hospital and the rural community. In two States, for example, provision of aftercare services to former patients from rural areas significantly reduced their rate of return to mental hospitals, and in a third, through the work of a two-man clinical team sent out by a distant State hospital, readmissions from four rural counties dropped 67 percent in 2 years.

Because of the scarcity of mental health professionals, the Institute has been concerned as well with helping rural areas make the most effective use of existing resources. In each of two North Carolina counties, a family-child program uses a "service guide" to maintain liaison with the nearest State hospital and also to help families find services close to home whenever possible. In New Mexico, mental health consultants were deployed to provide case consultation to social agencies and to doctors, lawyers, and clergymen. In New Hampshire, general practitioners and a mental health clinic have been enabled to get psychiatric consultation by TV. In Vermont, nurses with a reputation as natural crisis-interveners received special training in psychiatric concepts. In Kansas, one project has demonstrated that older people can be mobilized to help others, and a second is working to increase the counseling skills of all those individuals to whom people often turn for help.

Chapter IV

The greatest progress toward improving the mental health services of rural America has been made through the Institute's community mental health center program. As of 1973, NIMH had funded more than 200 centers to serve one or more predominantly rural counties outside standard metropolitan statistical areas. These rural centers constituted 40 percent of all funded centers. In their service areas were 30 percent of all rural counties and the same proportion of the people in such counties.

Rural centers, like urban, have an obligation to make mental health services readily available to everyone in their catchment areas. In fulfilling this obligation, they have had to meet problems that are common to most centers but fall with special severity on those in rural areas. Among them are problems of bringing services to people thinly scattered over territories ranging from a few hundred to 61,000 square miles and of filling staff positions. Rural centers commonly cope with the problem of distance by establishing branch offices and outreach stations. They attract professionals by extolling both the attractiveness of their rural locations and the opportunity offered for new types of service. They train indigenous nonprofessionals for work that used to be restricted to personnel with professional degrees. Many count heavily on volunteers—in some cases even for therapy—and one uses several hundred "community representatives" to help, or to get help for, people in crisis.

In addition to treating the mentally ill and the emotionally disturbed, the centers work to prevent mental and emotional disability by increasing the understanding of mental health principles and practices throughout their communities. Principal targets are teachers, doctors, nurses, clergymen, lawyers, judges, and other caregivers. Rural school systems in particular have been glad to contract for preventive mental health services they are unable themselves to provide.

As one measure of success, centers point to reductions in State hospital populations and also sometimes in admissions. As another, they point to their caseloads. One center started life with 400 patients on its rolls, inherited from a demonstration project; 5 years later it had 1,500.

Chapter V

As an indication of the wide range of services provided rural dwellers, one center includes a day treatment program for disturbed children and training programs for mentally retarded children. Another has a home for unmanageable adolescents and a drug rehabilitation program that includes a nightly open house for young people. A third developed a workshop for teachers on behavior modification and another on learning difficulties. The alcoholism program of one center includes halfway houses for alcoholics, a residential treatment center, and a company to employ recovered alcoholics long enough for them to earn a reference. The industrial therapy program of another center enables patients both to earn money and to acquire the work and human-relations skills they will need on the job after their discharge. This same center has established a "growth services" division to help both individuals and organizations realize their capabilities.

Chapter VI

As the Institute has endeavored to increase the number of community mental health centers and to expand and improve their services, it also has endeavored to raise the capabilities of State mental hospitals, which are still the primary mental health resource in most rural regions. The Institute's Hospital Improvement Program has enabled many institutions to make a concerted effort for the first time to rehabilitate long-term chronic patients. Through activating therapy, behavior modification techniques, halfway houses, foster communities, and other methods, the majority of the patients in such rehabilitation projects have been able to leave the hospital.

Through HIP projects, also, a number of State hospitals have introduced the geographic unit system, perhaps the most effective innovation in hospital administration in recent years. Other hospitals have used HIP funds to improve their services to older people, to establish children's units, to introduce a program for alcoholics, and to improve their treatment of the "criminally insane." A companion program, Hospital Staff Development grants, has enabled hospitals to give their staffs additional training and by doing so improve patient care. One hospital whose population dropped by 800 in 5 years attributes the reduction in large part to the NIMH-supported training program.

Chapter VII

To provide manpower for research on mental health problems, for delivering mental health services, and for training mental health workers, the Institute supports training programs that reach thousands of persons each year. Many of those programs are specifically for individuals already at work, or intending to work, in rural areas. Through grants for continuing their education, rural physicians are offered training in psychiatry; rural mental health specialists are helped to keep abreast of advances in their field; and persons in related fields—teachers, clergymen, social workers, nurses, and others—are trained to recognize persons who need help and to guide them to the services needed, or, often, supply the services themselves.

The Institute has been largely responsible for the development of community college programs that prepare people, many of whom intend to work in the rural areas in which they live, for positions as mental health workers in mental health centers, hospitals, and a variety of other social agencies. In awarding grants for such programs, priority goes to those emphasizing training disadvantaged persons and training for service to deprived populations. Numerous other training projects are directed at preparing blacks, Indians, and Spanish-speaking Americans for service to members of their groups.

For the Future

Thanks to the advances summarized above, rural mental health services have shown greater improvement during the last decade than during all the years preceding. Nevertheless, vast room exists for further gains. One statistic shows this clearly: More than two-thirds of our rural counties and of rural Americans are still not within the catchment areas of community mental health centers. While the Institute hopes that the Nation will eventually be covered by a network of such centers so that every person in need of mental health services will have ready access to them, it must be pointed out that *Federal funds to help in the construction of additional centers, whether urban or rural, are NOT available at the present time.*

As noted in Chapter IV, it is possible in many cases to operate a center from existing structures, making building funds unnecessary; one-fourth of all funded rural centers have not applied for construction grants. New centers can still be developed, then, if Federal help is needed only for staffing. Nevertheless, *even applications for staffing grants—for either new or existing centers—must be held up in some cases for lack of funds.*

There are other weak points:

- Although the poorest counties have been included in the service areas of mental health centers just as rapidly as rural counties in general, only a few of the 150 predominantly nonwhite counties have been included. And nonwhites in a predominantly white culture have been found in a number of studies to have a higher than average need for mental health services.
- Mental health programs in rural America are handicapped by the cost of space. The Federal salary dollar shrinks as the professional hours it buys are dissipated in travel over catchment areas of thousands of square miles. There is no provision for extra staffing dollars to recognize this type of inroad on professional time, and no Federal funds

are available for the additional operating costs. Related to this problem is that of transportation. No one knows how many people, withdrawn from neighbors and friends because of emotional problems, are never seen even in the outpost offices of mental health centers for lack of means to get there.

Another situation may be either a handicap or a challenge. This is the lack in rural areas of supportive services for families and children. Though no studies have been made of the subject, many rural centers are known to accept patients whose problems —at least in part—might be handled by less specialized agencies and to hold these patients in treatment longer than urban centers because there is no other agency to which they can be referred. This is a handicap if a center's resources become so strained that it cannot adequately care for all the people who need help. But it may prove a blessing if it inspires a center—as in the case of several of those described in Chapter V—to offer or sponsor some of the social services commonly found in urban areas. In fact, the ingenuity and foresight and enthusiasm displayed by the staffs of rural mental health centers in operating these pioneering ventures and in shaping them to meet the needs of their communities provide strong evidence that both present and future problems will be successfully met.

Increased interagency cooperation and collaboration in rural areas is likely. For, in the end, concern for neither the mental nor the physical health of rural Americans can be separated from such other concerns as adequate income, decent housing, proper nutrition, good schools, and a healthful environment. As the Institute continues to seek the information necessary for sound rural mental health programs, to guide and support the training of mental health manpower for work in rural areas, and to stimulate the development of rural community mental health centers and other service projects, it will continue and strengthen its collaboration with other Federal and State agencies concerned in diverse ways with the quality of rural life.

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